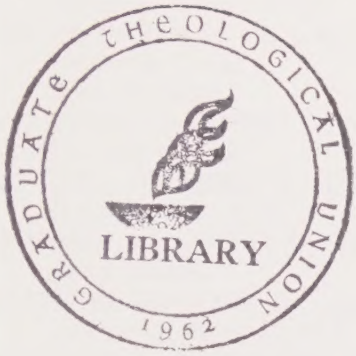
PASTORAL CARE OF THE SICK



PASTORAL CARE OF THE SICK

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Chapter One

TOWARDS A THEOLOGY OF PASTORAL CARE

Walter J. Burghardt, S.J.

A theology of pastoral care with special focus on the sick and the afflicted must address itself to three realities: (1) Because it is a theology, something must be said about the *Church.* (2) Because the focus is health, something must be said about *sickness.* (3) Because it is an apostolate, something must be said about the *people who care for the sick in the Church.*

I

First, then, the Church. Here the magic word is "mission"; for the Church *is* mission. In the totality of her being, the Church is an outreach; it is the Church's essence to be God's living outreach to the world. The Church is a corporate apostle; and an apostle is by definition one who is "sent."

In Catholic theology, mission has a high-level history; for in Catholic theology, mission is the story of God and man. Mission (from the Latin *mittere*) is a sending, and the root New Testament revelation has to do with a sending. The root Gospel revelation is the thrilling affirmation that God *sent* His only Son. Sent Him when? The day an angel brought the glad tidings to Mary. Sent Him where? Into this world, to every human being sin-scarred and tear-stained. Sent Him why? That the world might not die but have life—rich and full and overflowing. The first Trinitarian mission was God's unique outreach to sinful man: in Christ, God Himself was sent.

Consequent on this radical mission of God's Son is another mission equally incredible: the Father and the Son sent the Holy

Spirit. Sent Him when? On the first Pentecost. Sent Him where? To the Church. Sent Him why? Vatican II put it well: "The Holy Spirit was sent on the day of Pentecost, in order that He might forever sanctify the Church." (*Constitution on the Church,* 4)

Intimately wed to this sending of Son and Spirit is the mission of the Church: the Church is sent—sent by the Son in the Spirit. This mission was foreshadowed before the Church was born, when the Lord "called the Twelve to Him, and began sending them out, two by two, giving them authority over the unclean spirits. . . . So they went out and preached, bidding men repent; they cast out many devils; and many who were sick they anointed with oil, and healed them." (Mark 6:7-13)

But the definitive sending that constituted apostolate, that focused on a church, came only after Christ's resurrection. It started in fear, behind locked doors, when the risen Lord showed the disciples His hands and His side, and spoke that exciting sentence: "As the Father sent me, I also send you." (John 20:21) And with that He breathed on them: "Receive the Holy Spirit." (v. 22) That sending took on added meaning, the skeleton was clothed in flesh, on the mountain in Galilee where the Master issued His missionary mandate: "All authority in heaven and on earth has been given to me. Go, therefore, make disciples of all nations." (Matthew 28:18-19) That mandate was dynamized in a house within the City, where Jesus had bidden them wait to be "clothed with power from on high" (Luke 24:49), where "gathered together in unity of purpose" (Acts 2:2) "they were all filled with the Holy Spirit" (v. 4); and forth they went, a fellowship of faith and hope and love, so that "every soul was struck with awe, so many were the wonders and signs performed by the apostles in Jerusalem." (v. 43)

But the Church is not a Platonic idea serenely suspended in mid-air; the Church is people. And this people is not simply pope and prelates and priests; the Church is "the 'we' of Christians." We are the Church, all of us, we in community. We are sent. Sent when? Cardinal Suenens put it startlingly: The greatest day in the life of a pope is not his coronation but his baptism, the day of his mission "to live the Christian life in obedience to the gospel." Where are we sent? Like Christ, into "the world" to every being born to woman. Sent why? Like Christ "to preach good news to

the poor, to proclaim release to those in chains, sight to the blind, to set at liberty the oppressed." (Luke 4:18)

The Church, then, is mission, is sent, is apostle—all three mean the same thing. And if you know your New Testament, the implications are electric. For if to be a disciple meant to follow, to follow one only Master, to follow Jesus, to be an apostle meant to serve, to serve not oneself but others, to serve men. That is why the Twelve, Paul, and many another were sent. The Church is mission, and the mission is service. This is not pious poetry but essential ecclesiology. The primary thrust of the Church, and therefore of every Christian, is summed up in the impassioned confession of St. Paul to the Christians of Corinth: "I will most gladly spend and be spent for you." (2 Corinthians 12:15)

II

The Church is mission, and the mission is service. This is foundational, crucial, and it leads inexorably to my second main point: What has the Church's service to do with sickness?

The problem is not artificial. It forces us to confront two contrasting convictions of what the Church is all about. The first of these convictions is consecrated in an expression that has dominated Catholic thinking and writing for centuries: the mission of the Church is to "save souls." And your immediate, primary function as an individual Catholic is to save *your* soul. The Church is indeed a community of service; the service is salvation; and what is saved, in the first instance, is your soul.

This conviction should not be caricatured. There have always been Catholics for whom "soul" was simply a synonym for the person, with the accent on his spiritual nature. And no Catholic could lay serious claim to orthodoxy if his mind put no meaning to the syllables that fall ceaselessly from his lips: "I believe in the resurrection of the body."

Still, this vision of salvation reflects the traditional dichotomy of soul and body in which the soul is all-important, the body is subordinate. At its worst it reflects a popular misconception among Christians. For some the human body is nothing but an instrument, a tool of the soul. For others the body is a burden from which the soul cries for release. Such attitudes pay slender homage to God, fail to recognize that the body is an essential part of

man, that without the body man is a creature incomplete, that, whether in heaven or purgatory or hell, a separated soul, as Jean Mouroux phrased it, "still longs for its body with a purely natural impulse of love."

The point is, the body too yearns for redemption, to be ransomed from its slavery (cf. Romans 8:23), to come alive through the Spirit of God. This redemption, begun on earth when man's body is absorbed into the Body of Christ and ceases to be a "body of death" (Romans 7:24), will find its consummation in the glory to come—not merely in the soul's vision of God but in the transfiguration of the body, when the whole material world will share in the perfection of redemption, and there will be "a new heaven and a new earth." (Apocalypse 21:1)

All well and good; yet this could be a deceptive theology, particularly misleading for the health apostolate. If the Church's task is not simply to save the soul, neither is its mission to save soul *and* body. What the Church is all about (and this is the more nuanced Catholic conviction) is *man*; and man is an incredible oneness. Oh yes, he can be thought about as body and soul, flesh and spirit; for he is a fascinating wedding of material and immaterial, of what we can see-hear-touch-taste-smell and what escapes the most sensitive of senses and instruments. And still, the real, pulsating life a man lives is never one *or* the other. Aquinas at the acme of abstraction and Teresa ravished to ecstasy by a rose, Saul lusting for the blood of Christians and Augustine lusting for love in semi-pagan Carthage, none of them is disembodied soul or spiritless flesh. It is always and inescapably a man or a woman who is born and dies, who loves or hates, who gives life or takes it, laughs or cries, dances in sheer delight or winces in unbearable pain.

Precisely here I begin to touch realistically that critical question —what has the Church's service to do with sickness, with basic human needs? Till not long ago I would have answered: "Why, it's all rather obvious. Take sickness. In laying on your healing hands, in creating a situation in which other hands can heal, you are touching something sacred: the human body, a part of man, the material aspect of man's existence. This flesh, like man's spirit, was touched by the cross; it can be stirred to its depths by sin and grace; it yearns passionately for its ultimate liberation, for

life with God and without end. It is the temple of the Spirit. Handle not only with care but with reverence and love.

"Take basic human needs. In feeding a belly bloated with hunger or a mind wasted by ignorance, in finding work for idle hands and destroying the slums that breed all that is bestial, in helping an alcoholic to dry out or a drug addict to kick the habit, you are laying the groundwork for a genuinely human existence; you are preparing for the day when redemption can touch him. In a word, you are removing the *obstacles* to redemption: starvation and ignorance, unemployment and housing, liquor and drugs, and so on and so forth."

I do not retract all this, but I say it is inadequate. Sickness and basic human needs are an ecclesial apostolate not because you are in contact with a part of man (ravaged body or ignorant spirit), not because you are demolishing the physical and psychosomatic barriers that keep a man from touching God. Your apostolate is ecclesial because what you touch is *man,* man-in-process-of-redemption. In sickness and ignorance and all the human bondage that cries out for "welfare," you rarely if ever touch only the body, or only the spirit, or only an inhuman barrier. You touch a living person working out his or her redemption.

In sickness you touch not a man *with* melanoma, not a woman *with* scarred uterus. The whole package is one man, and the whole package is one woman. *He* is sick, not his chest; and *she* is sick, not her womb. That is why the medical response must be a human response, a rare welding of hand and heart, of professional skill and a warm compassion born of profound understanding.

But for the health apostolate this is not enough. I dare not constrict pastoral care to psychology alone, to therapy, to "the milk of human kindness." The specifically Christian dimension is that you are touching a human person in process of redemption. Every listing in the massive encyclopedia of sickness, from the schizophrenia that disintegrates a total personality, through the cardiac insufficiencies and the intestinal diverticula, down to the acne on an adolescent's cheek, is intimate to a person. A disease is not something objective, outside of me; it is part of me, it is I, for a time or terminally—as really and existentially part of me as is my hand or my hearing, my faith and my fears, my loves and my deepest yearnings. No matter what my explicit belief or unbelief,

in illness I work out my destiny as a person: I grow or I diminish, I spend and am spent selflessly for others or selfishly for myself; yes, I live or I die. And if I am a Chrstian, sickness (like gladness) should be my share in the life of Christ, my role in salvation history, my way of realizing a relationship of love with God and with God's images on earth; and I simply cannot divorce this religious movement from what disease does to me as a man. If disease diminishes *me,* it diminishes my Christianness. If sickness strengthens *me,* I take a giant step (or many small steps) toward my salvation. The equation is as simple as it is profound: sickness = I, and I am a person in process—in process of redemption.

And, of course, in all genuine illness, I face to some extent the ultimate mystery: death—that singular and solitary event which gives meaning to all that has gone before. For a Christian, death dare not be an episode I undergo; it must be an act I personally perform. If that is true, if the ultimate death is not sheer resignation but a yes, an "I do," then each partial death, each movement towards the decisive death, should be itself a yes, an "I do." Not fatalism; not a refusal to be healed; rather the Christian realization that *all* our gethsemanes make sense only if they prefigure a final cross, only if at every stage of our tortured pilgrimage we can murmur "Into thy hands I commend my spirit."

As with sickness, so with basic human needs: an apostolate is ecclesial to the extent that it is a service to living human persons in process of redemption. Each "case" you touch with counseling or welfare, with inspiration or bread, is paradoxically a person and not a person. A person, for in each "case" you have at least the shell of humanity, the hidden potential to know and to love, the stifled cry for freedom, the mute yearning to relate to man and to God. Not a person, for dignity is destroyed or in danger, self-esteem is no more, and an image of God crawls along on the bitter edge of humanness—faithless, hopeless, loveless.

How bring out the latent person? St. Vincent de Paul was splendidly suggestive: "Unless you love, the poor will never forgive you for the bread you give them." Unless you love. . . . There was a time when love might have lifted the oppression of the black, but it took a court of law to compel where the Sermon on the Mount could not persuade: too little love too late, and now there is little but hate. Unless you love, those to whom you minister will remain

not only unloved but unloving. Unless you love, pastoral care will be cases and not persons; for to be a person is to be related, in a relationship of love, to another person or to a community of persons. What a frightening responsibility we Christians bear, what a frightful burden of guilt! Millions of God's little ones, millions of God's outcasts, are incapable of loving because they have never been loved. Because *we* have not loved them.

Service to basic human needs is ecclesial because these shadow persons are in process of redemption: they are working out their redemption *now*. This is not some sort of preparation for redemption: fill their bellies or their minds, give them jobs or break their habit, and *then* you can preach the gospel to them! No. The passion of Christ is being played out now, and each time you touch another human being you are preaching *a* gospel. For decades now, the meeting place of God and man has been, for ever so many, not so much an altar rail as a stinking slum in Washington or a rat-plagued tenement in Harlem, a street in Selma or a jail in Jackson, a vineyard in Delano or a decaying schoolhouse in Appalachia. God is there; His Christ is there; but God and His Christ are felt there and seen there and heard there only in our love. Only thus will "the poor have the gospel preached to them." (Matthew 11:5)

III

I have already said much about those who exercise pastoral care in the Church; let me simply draw the several strands together.

First, illness and human misery call for the Church's service, not simply because care and concern and compassion are so human, but primarily because the Church is Church, with an inescapable mission to man-in-process-of-redemption. To the extent, therefore, that this is what you want to do, not from fear or force but from love for God and His image, you share in that apostolate.

Second, as with the Church in general, so with your apostolate in particular. The Church is not pope or bishops or clergy; the Church is the people of God. And the basic condition of this people is equality—equality because each possesses, is possessed by, the same Holy Spirit. Similarly, pastoral care, the health apostolate, is not bureaucrats or religious or nurses—or even priests; it is the community of all who have committed themselves to God in His

crucified children. And the basic condition of this community is equality—equality because each is an apostle, is genuinely "sent," is on mission from the Church to man working out his salvation in anguish and agony.

Third, within this basic equality there are degrees of involvement. Priests and religious have a role to play that should distinguish their service. Not precisely because they are vowed in a special way to God. Rather because ideally their vowed existence permits a totality of commitment, a singleness of purpose, rarely allowed the laity. And because ideally a community of servants (priesthood, religious congregation) lends a graced strength to the individual, who in isolation might well be dimished or destroyed by an apostolate imprisoned in human fears and tears. And because ideally a community has an unparalleled witness value, in that it trumpets with one glad voice the gospel tidings that human sickness is not waste and need not be frustration, that disease and death are redeemable and redeeming.

Ideally. . . . The tragedy is that the real is at times in contradiction to the ideal: where laity shame clerics and religious with the quality of their commitment, where community drains an individual of strength, where the community witness to redemptive suffering is muted or drowned out by joylessness, by forced servitude, by internecine bickering, by an impression that the vowed servant has little understanding of his mission and even less fulfillment therein.

Fourth, the Catholic mission of service is not just another social-service agency. I do not mean that you indoctrinate the dying and convert the comatose. I do mean that a health apostolate, pastoral care, will prove sterile without spiritual people. Your commitment to this most Christian of causes, the redemption of the whole man, will be vital and effective only if you believe not merely in man but in God; only if you pray as well as work; only if with every syllable and gesture you preach not man's death but the Lord's death for man—until He comes.

Chapter Two

HEALTH CARE DELIVERY IN THE UNITED STATES

Frederick H. Gibbs

I. INTRODUCTION

This chapter will describe, briefly, the evolution of health care delivery in the United States. Major emphasis will be placed on aims, philosophies, and social organizations of the 1960's and 1970's. Some background references will be made to the evolution of health care in Europe, where its influence on health care delivery development in the United States seems relevant.

Little will be said about health care delivery prior to 1800. Only the most pertinent events of the 19th century, those which seem to lay the basis for 20th century health care delivery, will be described. The 20th century events are divided into two periods, those of the first 60 years and those of the 1960's and 1970's.

II. HEALTH CARE DELIVERY BEFORE 1800

In the long period before the beginning of the 19th century there are disconnected accounts from many cultures of the various means that were used to treat human sickness and injury. From early times the conditions needing attention seemed to be divided into loathsome diseases that were to be isolated, such as leprosy, plague, mental conditions, and the broad range of other physical conditions for which no isolation seemed to be required, such as ordinary disease, child birth, and injuries, particularly those that were the result of military service.

The methods of treatment of each, while they had some similarity, varied. Those having contagious or abhorrent diseases such as leprosy and plague were neglected, avoided and segregated. The mentally disturbed and the insane were beaten, placed in prison, or otherwise degraded. Special help and midwifery for child birth are referred to in ancient documents. For serious injuries, particularly in the military, individuals were taken along with the forces, who might have some skill in the stopping of bleeding, the amputation of limbs and the setting of fractures.

For the great mass of physical ailments few facilities or hospitals existed. While over the centuries there came to be a growing number of places of treatment, called by one name or another, these were primarily for those who had no resources of their own. The greater number of people who suffered were treated or mistreated in their homes by members of their families, by quacks, barbers, witch doctors and occasional men of good will (who had attempted to master the primitive treatment techniques of their day). Or they suffered without care. So, except in those cases where society provided pest houses and other means of isolation; where military commanders made efforts to safeguard their fighting forces; and where temples and religious hostelries provided charitable care—treatment was home-centered. Successful attempts to monopolize most of the practitioners of medical care, who were most expert, were made by the wealthy, the noble, and other elites.

The belief was widespread that disease, illness and sometimes injury were punishment for offenses against evil spirits or deities. It was also popularly believed that some secular people in powerful positions and some religious devotees had mystical powers that might enable them to cure disease or injury.

Although there were notable exceptions, superstitious and unscientific approaches to the care of the sick, the injured and the mentally ill were prevalent. For the most part a cloud of indifference, ignorance, superstition, malpractice and fear has darkened most of the centuries of man's life. It was not until the 19th century that greater stability in social structure, in learning, in scientific investigation, and achievement brought about notable change.

III. 1800 TO 1900

By the beginning of the 19th century there were numbers of prestigious hospitals both in Europe and the United States. Most

became centers of research and study, frequently were operated in connection with Universities, and were used by skillful and noted medical and surgical practitioners. There is little doubt that medical care as a science was advanced by the study and treatment of the aggregations of welfare cases, by medical and surgical practitioners who kept records of their treatment and who passed on the results of their studies to their students. More and more medical and surgical practitioners required certifications that they had practiced in hospitals and/or had studied under practitioners of note. As their number increased, more and more communities gained better trained doctors who engaged in general practice. These doctors of medicine engaged in rudimentary preventive medicine, sometimes dentistry, care of the acutely ill and the injured; they compounded drugs and filled prescriptions for their patients. These physicians spent less time in these pursuits as apothecary shops and ultimately pharmacies opened in communities.

Most hospitals were of the voluntary or privately owned varieties. However, in 1802, pursuant to an act of the U.S. Congress, two public health hospitals for the care of sailors were set up, one in Boston and one in Norfolk. They were known as Marine Hospitals, thus laying the foundation of what ultimately became the U.S. Public Health Service.

Primarily in Europe but also in the United States tremendous progress was made during the first half of the 19th century in medical science and education as well as in organization for delivery of health care. We find vaccination for small pox at the end of the 18th century and immunization for certain diseases and isolation of bacteria by Pasteur in the early part of the 19th century. By the middle of the 19th century chloride of lime began to be used as an antiseptic for obstetrical cases by Semmelweiss and by Lister in preparation for surgery; and the use of nitrous oxide ether and chloroform for anesthesia also began. Doctors' concern about the quality of their practice was evidenced by the formation of the American Medical Association in 1847. Concern about the quality of preventive medicine and public health was evidenced with the formation of the American Public Health Association in 1872.

The discovery of means of preventing the spread of bacterial infection and of the various antiseptics made hospital care much less hazardous. Death rates declined phenomenally. The number

of students taking up medicine increased and the number of hospitals and private clinics by doctors began to grow. Particularly during the last half of the 19th century, hospitals sponsored by various organizations and groups sprang into being, until hospitals were found in all of the major communities of the United States.

Nevertheless, the practice of medicine took place largely in the offices of doctors and in the homes of the afflicted. Gradually, as information spread about the decreasing hazard of the hospital as a place to be treated, patients who could pay and those who were sponsored by their work organizations began to go in increasing numbers to hospitals for surgical treatment. The measures taken to prevent the spread of infections became more elaborate and the tools of surgical performance and medical diagnosis became more numerous and complicated. It became more desirable that certain kinds of medical conditions and most surgical conditions be treated either in doctors' offices or in hosiptals.

Now began the development of private rooms in hospitals for the elite and wards for patients of lesser means and indigents. Slowly the demand grew for hospitals on the part of people who could pay; and accommodations for their care improved. These hospitals were largely in the charge of medical doctors, nurses or housekeepers. Occasionally a business manager was employed. Fulltime managers were increasingly retained as hospitals grew larger and greater amounts of money were available to pay for supplies and salaries instead of relying on donated supplies and help.

A greater interest in the hospital, not only as a philanthropic institution but as a business enterprise, developed as the century wore on. In 1899 some administrators founded a personal membership organization of Hospital Superintendents. Early in the 20th century it became the American Hospital Association, an institutional membership body.

During the latter part of the 19th century a tremendous surge in the development of medicine as a science continued, as did growth in the number of community hospitals for acute care. These institutions, although still primarily for people who could not pay, were beginning to be used on a larger scale by individuals who were formerly treated in their homes and who for the most part had means to pay both the doctor and the hospital.

Nevertheless, doctors continued to engage in what has been called "solo practice." They engaged in a species of preventive medicine on demand, and for the most part took care of acute cases either in their offices or in the homes of their patients. Only a minimum of their practice took place in the hospital. During this period the drug store developed, moves were made toward the development of more rational methods for the care of the mentally ill, and better measures were adopted for the isolation and treatment of people who were afflicted by contagious diseases. The beginnings of understanding on how to prevent diseases by early isolation of individual cases, careful preparation of food, the heating of water, and immunization led to an increase in potential longevity. But the majority of the population had little or no medical care and, at least to some extent, still used methods of treatment grounded in superstition and ignorance, including dependence on herbalists, quacks, medicine men and nostrums of little value. Society awaited the advent of the 20th century for the further miraculous developments in medical science and the great growth of the hospital as its principal acute health care institution.

IV. 1900–1960

The expansion of the hospital's role in acute care continued during the first 60 years of the 20th century. Parallel progress was made in developing drugs to combat disease, X-Ray photography, laboratory methods, diagnosis, use of radioactive materials, remedies or prophylaxis for many of the most fatal diseases, surgical techniques and use of prostheses.

Other factors contributed to the increase in the number and size of institutions. Among these were the general increase in population and greater population concentration in urban areas. Contributing causes were general affluence, ease of transportation, better dissemination through news media of the possibility of improved care in hospitals and increasing endorsement of hospital care by physicians. Consequently less and less care was given in the home.

Meanwhile the stable communities of formal patriarchical family groups began to break up due to industrialization, better transportation, and the resulting greater mobility of the general population, particularly the young. This in turn made it less possible for members to belong to self-sustaining family units and caused notice-

able effects on treatment not only of acute ailments but also of chronic illnesses, and problems of aging.

Specialization

With the great increase in medical knowledge and in the role of the university as a repository of this knowledge and the location for its teaching, there came greater specialization among physicians, nurses, and administrators. In fact, increased specialization took place in all activities performed in the delivery of health care.

This increase in specialization reduced the number of general practitioners and the ability of the general practitioner to diagnose and treat. The proliferation of medical specialists made it increasingly necessary for patients to have the services of more than one doctor of medicine. Thus, as diagnostic and treatment procedures became more complex and knowledge grew more fragmented, it became less and less possible for a patient to find in any one doctor's office all of the means for diagnosis and treatment.

This led to an invasion of the hospital by the doctors of medicine and the formation of groups of doctors to perform the services formerly provided by single practitioners. All of these factors, as well as an increase in population, tended to promote an even greater number of hospital beds and adjunct services.

Administration and the M.D.

The administration of hospitals began to change. Whereas formerly hospitals may have been managed by doctors of medicine who spent a minimum of their time in administration, assisted by nurses, housekeepers and business managers, now doctors of medicine began to be less and less able to divide their time in this way. This led to growing dependence on administrative assistants. Ultimately a divorce between treatment and administration took place.

Before and at the beginning of this period the ranks of hospital administrators included doctors of medicine not in active practice, nurses who had forsaken nursing, and others who by bootstrap methods had qualified themselves to perform the elementary administrative services in the growing health care institutions. Beginning with the formation of the Association of Hospital Superintendents at the turn of the century, however, hospital administration took steady strides toward professionalization. Milestones in

this process were the establishment of the American Hospital Association in 1910, the American College of Hospital Administrators in 1934, and of graduate programs at universities for the development of new administrative input for health care institutions. By 1960 distinct professionalization in health and hospital administration had taken place.

With the exception of a decreasing proportion of doctors of medicine who had forsaken medical practice for administration, doctors of medicine in the voluntary hospitals turned hospitals into workshops for the treatment of their paying patients and left professional non-doctor administrators to manage hospitals. This led to a pattern of intermtitent conflict between the medical staffs and administration. The medical staffs formed self-governing bodies to bring patients to the hospital and provide medical care for them. But the medical staffs also charged separately for their services, determined the length of stay of the patient in the hospital, gave orders to the hospital personnel, and made levies on the medicine and supplies of the hospital—all without more than token integration into hospital organizations. They were not disposed to take instructions from administration. Hospitals, by separate billing, levied charges against the patients and in fact became dependent for survival on paying patients, whom only the M.D. could admit. As a result of demands made on hospitals by doctors of medicine, in the name of their paying patients, the doctors of medicine dominated the power structure of the hosptial, beginning at the turn of the century and to an increasing extent during this entire period.

The situation was somewhat different in other than voluntary hospitals. Considerable numbers of proprietary hospitals sprang up over the country, particularly in those areas where there were no voluntary or community hospitals. These proprietary institutions were for the most part both hospitals and clients, owned by physicians through stock holding or other mechanisms. This allowed M.D.'s to devote full time to medical practice but still dominate administration through managers employed as their administrative servants. With the exception of the Veterans Administration, in the government services doctors of medicine continued as the professional administrators of hospitals for the most part. In the V.A. large numbers of M.D.'s had been replaced by non-M.D. professional administrators by 1960.

But M.D.'s continued to fight integration into the organizational

structure of non-governmental hospitals. The American Medical Association insisted that M.D.'s should continue in solo practice, and should render separate bills for all services performed as being in the best interests of patients. This seemed illogical in view of increased specialization among M.D.'s which led to the frequent need for the services of more than one physician to diagnose and treat a single patient.

Kinds of Patients

Another striking development of this period was the overwhelming increase in the number of paying patients treated in clinics and hospitals. Originally, the majority of patients treated in clinics and hospitals were either welfare or indigent patients whom doctors of medicine cared for as a charitable duty. But doctors derived their incomes and gave the bulk of their attention to private patients of means who, prior to this time, were treated, for the most part, in their homes. With the increase in the flow of paying patients to the hospitals, there was a lessening of the proportion of welfare indigent patients admitted. This caused an overall lessening of home and office practice and a parallel increase in hospital practice. Payment by the patient was divided in two parts: fees to the doctors and fees to the hospitals. As a consequence, general practitioners declined in numbers and in reach. It became more difficult to find M.D.'s to make house calls. The availability of general health advice for minor conditions and preventive care substantially decreased.

Public Health

There were marked advances in the institutionalization of preventive medicine during this period. There was a great development in the services provided by the U.S. Public Health Service, State Health Departments, and City and County Health Departments. Public Health projects were undertaken, including the drainage of swamps, the oiling of mosquito-infested areas, more sanitary disposal of wastes, vaccination and immunization of children and adults, and the provision of emergency health care to disaster areas through Public Health Services and the American Red Cross.

But massive self-treatment also continued as did dependence on traditional remedies, cure-alls from internal medicine men, and improperly advertised drugs and nostrums. These abuses and

others led to the passage of a pure food and drug act in the early part of the century requiring government supervision over advertising and production of food items and medicines offered to the public. The rise of the great drug companies, their research departments and their outlets through public pharmacies, together with the professionalization of the pharmacist, undoubtedly led to a better quality of minor self-treatment.

Governmental Hospitals

During this period governmental hospitals increased greatly in number. This was particularly noticeable after World War I with the great expansion of Veterans Administration hospitals. After World War II, with the armed forces not completely demobilized, large numbers of Army, Navy and Air Force hospitals continued in active service. The doctors of medicine in the governmental hospitals were integrated into the hospital organizational structure and were subject to administrative chiefs as contrasted with the nominal membership of medical staffs in the structure of voluntary hospitals.

Long Term Care

Also, during this period there was an expansion of facilities for the care of the mentally ill, as national sensitivity developed about the manner in which these long-term care patients were taken care of in mental hospitals, nursing homes and extended care facilities.

Group Clinics

It was during this period, and particularly immediately after World War I, that another type of practice grew, in spite of intense opposition from the American Medical Association and State and County Medical Societies, until it became by the middle of the century an important part of the means of the delivery of health care to that part of society that could afford to pay. Young doctors in the military services during World War I discovered a kind of total and comprehensive health care for those under military jurisdiction. Since all of the doctors of medicine were on salaries, and since all the patients came to clinics and to the hospital for treatment, patients were examined by the various specialists in the hospital, given the care needed to restore the whole body to health. Since the military organizations were sensitive about days lost in

the hospital, doctors paid close attention to the living conditions of those entitled to care. They made frequent physical examinations and gave a maximum of preventive care to servicemen as well as their families. After World War I numbers of these doctors, sold on the clinic-hospital approach, formed private group practice clinics, consisting of doctors of various specialties. A typical group was the Ross-Loos Clinic in Los Angeles, which offered those who paid a monthly fee complete medical coverage for all family members. A losing battle was fought against this practice by the American Medical Association and the County Medical Societies. In spite of this opposition, it ultimately became a prominent form of health service delivery.

Financing

Later came other forms of pre-payment, notably Blue Cross, Blue Shield, and the indemnity plans offered by insurance companies. These pre-payment plans tended to increase the financial stability of hospitals, as well as the number of patients who came to them for care. They began to cause marked changes in hospital financing.

In the early days of voluntary hospital and clinic operation, hospital construction, equipment and operation were financed by a kind of collective philanthropy, joined in by physicians and by members of the community who gave services, things and money. Earlier, these organizations were primarily for welfare cases. Particularly in rural areas, communities sanctioned the admission to the hospital of patients who could not pay. At the end of the year communities supported fund drives to help hospitals or other health care institutions make up deficits caused by the care of indigent patients. When equipment, repairs, or new buildings were needed, communities undertook drives to raise the necessary funds to meet such capital requirements. As time passed more of the costs were met by charges to paying patients. Since these patients could only be admitted by private physicians, the doctors maintained their strong influence over the hierarchy of the hospital by providing, through their admissions, a means of financing for the institution. During this period philanthropy diminished. Government agencies contributed larger amounts of money for indigent patients. Since government funds usually covered only a part of welfare costs, more and more the cost over and above the amounts

received from governmental sources or philanthropies was prorated against the patients who could pay.

However, tax-supported aid for hospitals became more varied and greater. This period saw the beginning of increased federal aid to the building of hospitals through Hill-Burton legislation. Later came increased state benefit plans for indigent care and for older people through various means (among the latest of which are Medicare and Medicaid). Industrial organizations, pressed by labor unions, provided fringe benefits covering some of the costs of medical care for workers and their families. Other legislation provided for partial payment by the government of those who were injured while employees in various organizations. As this caused increases in taxes, communities became less and less willing to make up deficits or give funds for capital costs. This fostered financial budgeting and forecasting and allocation practices common in industry.

Toward the end of this period, as costs of care increased, it became evident that larger numbers of people would demand care even if they did not have the means to pay for it. Through the news media they were constantly made aware of the resources and skills available to alleviate and prevent illness. They became restless and discontented when these were not accessible to them, too. This led to moderate extension of public health activities, increases in aid to welfare patients, and the expansion of city and county hospitals for the care of the large concentrations of indigent people in urban areas. However, by 1960 health care was given primarily in hospitals, clinics and in long-term care institutions largely for people who could pay. While there was growing pressure for greater care of indigent patients in health care institutions, there was little success in getting tax funds sufficient to cover the entire cost of caring for the medically indigent. Greater efforts were made by the public health services, visiting nurses, by hospital clinics in city-county installations, for the primary care of indigent cases.

KINDS OF INSTITUTIONS FOR DELIVERY OF HEALTH CARE

By 1960 the health care delivery patterns of the country could be categorized according to control as: government, proprietary, and voluntary (including religious).

Government Hospitals

Among the governmental hospitals the federal government owns the largest number. These include the military chains in the United States and overseas (consisting of the hospitals of the Army, Air Force and Navy); the State Department chain for the care of State Department personnel overseas; and the Public Health Service chain for special groups, consisting mainly of leprosariums, federal prison hospitals, and special purpose hospitals.

The largest chain is that of the Veterans Administration which has more than 160 hospitals in the United States providing care primarily for military-connected conditions.

Various states have numbers of psychiatric hospitals, retardations centers, and hospitals for the care of tuberculosis patients.

Cities and counties tend to have hospitals primarily for the care of general acute patients who are medically indigent.

Proprietary Hospitals

There is a large number of proprietary hospitals in the various states. Some are for acute patients and some are for long-term care patients.

Voluntary Hospitals (including religious)

Hospitals for the care of the general public are known as voluntary or community hospitals. For the most part they have been built with funds raised in the community, sometimes contributed to by religious organizations, government loans or grants. Most are acute hospitals, although some are specialty hospitals. They have about half of the hospital beds in the United States and take care of by far the greater number of patients.

Hospital Chains

There are also miners' chains serving the hard coal region of the Appalachian Mountains; a railroad chain of hospitals; chains of religious organization hospitals; and chains of proprietary hospitals.

Clinics

Clinics represent another element of the method of delivery. Originally, the greater number of general group practice clinics were proprietary; but a growing number are set up on a non-profit basis. Some of these are hospital-based. Some charge for individual treatment and others require membership, with the payment

of monthly fees to cover the costs of all services provided. An increasing number of specialty clinics for mental health have been set up: some as separate community mental health clinics, others in connection with psychiatric hospitals, and some in general acute hospitals. Some other specialty clinics exist, but the larger number of people is served by the clinics offering general services. While mental health clinics are operated with no cost or minimum cost to the people who seek their services, most other types of clinics are primarily for people who can pay.

Long-Term Care

This area received a great deal of attention, particularly during the decade prior to 1960. While long-term care institutions cover mental hospitals and mental clinics, the greater emphasis during this period was on the nursing home or extended care facility. Some nursing homes were operated by the government, the majority were proprietary, some were non-profit, and a few were hospital-based. These institutions were primarly for people who no longer needed care in an acute hospital but had conditions for which continued nursing and rehabilitation were necessary before they could return to productive activity. By far the larger number of people in nursing homes required nursing care or custodial care because of chronic conditions and advanced age.

Public Health Activity

Federal Public Health activities were carried on through state health departments and federal institutions of the U.S. Public Health Service. Similar services on a regional basis were provided by State and City-County Health Departments. Health services of these agencies were provided without cost to the beneficiary.

Some of these same services have been provided incidentally by M.D.'s in private practice and most frequently for pay. But with the diminishing number of general practitioners, and M.D.'s who make home calls, these services have decreased.

Self Treatment and Prevention

Much self-treatment continues, guided by publications of Federal and local governments and by general news sources. The role of commercial drug companies, their advertisements and outlets through local pharmacies must also not be overlooked as aids to self-treatment and prevention of illness or injury.

GENERAL CHARACTERISTICS OF DELIVERY METHODS DURING THIS PERIOD

Although occasionally referred to as a system, health care delivery in the United States is not systematic, is not integrated and is not equally available to all. Those individuals who had acute conditions and desired care contacted private physicians. For minor conditions they were given advice or prescriptions. For serious acute conditions they were admitted to the hosiptals. For this care both hospital and medical bills were rendered to the patient for payment. Limited numbers of patients who *could not* pay, were taken care of in private hospitals by reporting to hospital emergency rooms or clinics. Doctors who gave care donated a fraction of their time for these services. Hospitals attempted to collect welfare payments to cover costs and allocated uncollected costs against the general cost of operation, which were the basis for the bills rendered to paying patients. In areas of large urban concentration, city and county hospitals were erected to care for indigent patients who presented themselves or were referred to them. Limited care, largely for the more acute conditions, was all that could be given. State, county and city Public Health Services tended to make visits among registered indigent patients. Their visiting nurses gave advice and routed many patients to the hospital and clinics with the hope they might receive some care.

Except in the case of some group health organizations and in reservations under the control of the military, there was no provision of total systematic preventive care and acute care on a continuous basis. Even in these, care was given only on the demand of individual patients or their doctors, largely for acute conditions and only to the extent resources were available to reimburse the physician or the institution for this care. Care for indigents was random and not complete, even when requested.

V. DELIVERY PRACTICES AND METHODS 1960 TO THE PRESENT TIME

By the beginning of the 1960's growing dissatisfaction with delivery of medical care became more articulate and began to have noticeable effects on government at all levels (including the courts), on the institutions for delivery of care, and on doctors of medicine. Corresponding effects were noticeable in the education

of those studying to play major roles in the administration and planning of health care delivery.

CHANGES IN NOTIONS AND PHILOSOPHIES

Distinct changes in the general notions or philosophies governing the provision of care appeared among national legislators. During this period legislation was passed which, when interpreted, seemed to mean that all people residing in the United States had a right to health care around the clock for both preventive and acute conditions from birth until death. The notion developed that institutions for the delivery of care, whether non-profit or proprietary, were public utilities and should be subject to the same types of regulation to which other public utilities had been subjected. Thus new notions became prevalent about governmental regulation of hospitals, doctors of medicine, administrators, prices, and authority structures.

The effects of the application, or further application, of socialistic or collectivistic ideas increased the centralization of power at the Federal level and resulted in increased income taxes and other taxes of many kinds to provide: free roads, free schools, social security, workmen's compensation, unemployment payments, regulated collective bargaining, and indemnity awards to individuals whom courts decided had suffered either material or psychic injury. These ideas seemed to increase in volume as the affluence of the country increased, as larger numbers came into the registered work force, as unemployment either increased or became more noticeable, and as increasing mass concentrations of poverty-stricken people were found in urban areas. Thus the concepts of free enterprise, the Protestant Ethic, the nobility of work and regular employment began to be more generally questioned in the face of an economy which could prosper and manufacture more of all manner of products without use of all the employable population. This further strengthened the arguments of those who fought for increases in the kinds of social legislation which would provide more even division of benefits of the productivity and affluence of the society to all of its members, whether they had work income or not. These notions became more positively directed toward health care and brought health care into a limelight from which it appears it may never escape.

The critics claimed that the health care methods which had developed in the United States provided piecemeal care and catered primarily to the elites, that health care was provider-oriented and careless of consumer interest. They insisted all care was incomplete—for both paying and non-paying patients—in that it was oriented to the care of acute conditions primarily and that little of even this care was given the indigent except as a matter of convenience (and then within the limits of inadequate philanthropic and tax-originated funds provided for the medically indigent). It was pointed out that costs were increasing at a phenomenal rate and not only had technology increased costs of care but the hospital was luxuriously fitted for upper-middle-class styles of living; that the charges bore little relationship to the necessary cost of institutional care and of doctors' services. It was claimed that parts of the care that were given by hospitals for indigent patients were done largely for the convenience of medical schools and teaching programs in medicine and nursing, even though flavored with philanthropy and willingness to devote a part of the time and resources for reimbursed indigent care. The claim was made that even in the city-county hospital there was not enough money for care, that solo practice of medicine made it difficult to provide integrated and inexpensive medical care, and that all hospitals were difficult of access. Even the population having health insurance or other means complained that the prices were increasing entirely too fast; that it was difficult because of solo practice to secure the services of doctors; that item pricing, the additional overhead for the poor, and the cost of inefficient overall organization—all were unfairly borne by them. They further claimed that it was difficult to get home care from doctors or to persuade doctors to make house calls, and that individuals away from their communities found it difficult and sometimes impossible to establish connections with private physicians. They were forced to flood out-patient clinics and emergency clinics in hospitals as emergency cases, whether emergencies existed or not, as being one certain way to force the provision of needed medical attention.

Mostly private nursing homes of different grades offered a refuge to increasing numbers of older people, for whatever the individual sponsor or aged person could pay. Their numbers rapidly increased, not only because of longer life expectancy, but also because many were displaced due to the mobility of the

younger members of their families. Since the quality as well as the amount of care seemed to be geared to ability to pay, or to welfare payments and pension incomes, the quality of care became the target of investigation and attack until the national conscience was aroused. Emphasis was laid on the lack of social recognition and monetary subsidies for those who could no longer produce living income or, if able, were nonetheless barred because of age from employment in productive work.

To sum up: It was pointed out that the Public Health Services, whether Federal, state or local, were not adequate for preventive care; that clinics and hospitals are acute care-oriented and largely for people who could pay; that those without income and those who could not produce incomes because of age or infirmity—become second-class citizens. Thus the health care indigent lived in poverty-stricken deserts in a country possessing great affluence and the highest standard of living yet achieved by man.

These claims, some supported, some unsupported, some denied, some undenied—and all probably the objects of inadequate investigation—nevertheless were endlessly repeated by the news media, until they became a basis for popular criticism of the reported methods now used in the country for the provision of care.

EFFECTS

Effects on Legislation

This gave rise to legislation providing payment for institutional care and physician's care. Popularly called Medicare and Medicaid, this financial help by the Federal government gave some relief, although it was conditional on the observance by institutions and doctors of other social legislation relating to discrimination because of race, ethnic origin, or sex, on recognition by voluntary accrediting bodies, and was subject to state and local ordinances. But on the whole, these steps appeared to be inadequate in that they were not adapted to the other methods used to provide health care to the nation. Thus notions about comprehensive health care, regional planning, setting up of health maintenance organizations, the development of national health insurance to finance cradle-to-the-grave care, the sponsoring of legislation on piecemeal basis, all have added to the general ferment and dissatisfaction with the present social organization for the delivery of health care.

Increased government financing—in the form of grants or loans for mental health clinics, oridinary clinics, hospitals, nursing homes, extended care facilities and health maintenance organizations—was followed by steady increases in taxes and steadily increasing costs of health care. Government aid and the upward swing in taxes seem to have choked off or discouraged much local philanthropy. Most health care institutions faced the absolute requirement to develop more rational financing methods. They have begun to initiate the financial planning and budgeting methods developed in profit-making organizations. They have resorted to raising charges to cover the amortization of equipment and the accumulation of capital funds for building. Demands for further expansion of health care facilities have led to willingness of banks and other organizations to lend money to health care institutions, provided that sound methods of financial planning of cost and collection are established. This has had the further effect of tying the hospitals to pre-payment plans and to the demand for the complete recovery of costs from government for the care of patients who cannot meet their bills.

This in turn has inspired the development by hospitals of methods used in industry to secure more economical employment of personnel time, the development of sounder methods of work, and less expensive employment of all resources.

The imposition of regulations by governmental authorities at the Federal, state, and local levels made much more complicated the task of top administration. It has caused, according to some claims, an increase in the numbers of people required in business offices and in time spent in overall planning. It has taken some aspects of control out of the hands of hospitals, clinics, nursing homes and extended care facilities. Occasionally, this seems to have been so disastrous that institutions have refused to participate in government reimbursement programs because of the difficulty or inability to meet auxiliary conditions required for reimbusement. Unreasonable controls by government, it is claimed, have resulted in serious financial losses to many institutions, particularly nursing homes, extended-care facilities and long-term care divisions of hospitals.

The increase in consumer complaints and dissatisfaction carried

to the courts has caused additional expenses and problems for institutions in that the number of lawsuits has greatly increased. These lawsuits generally involve not only the doctor but sometimes the nurse, the administrator, and the board of trustees. The number of favorable decisions for the complainants has been very great. This has the result of increasing the need to predict possible unsuccessful consequences or unjust claims arising from treatment. It has caused an enlarged use of consent forms for dangerous procedures in order to escape legal blame. It may have made surgeons reluctant to treat or to recommend treatment in problem cases.

This has resulted in greater increase in the power and authority of the health care administrator. These regulations are passed through him for implementation in the organization, making the administrator and his board responsible for organizational behavior. This seems to have lessened the power of the medical doctor in controlling certain types of health care practices and decisions made in the institutions which he uses as his workshop.

EFFECTS ON ORGANIZATION FOR HEALTH CARE

More and more the influence of regional planning agencies for the development of integrated and comprehensive health care is being felt. In some instances additions to hospitals or new hospitals themselves cannot be built without clearance from these agencies, and, in some cases, from state health authorities.

In hospitals there has been a great growth in the use of emergency rooms, ambulatory care clinics, and the development of clinic practice, both as a part of the hospital and without the hospital, in order to meet the demand for care caused by the abandonment of house calls and office practice on the part of the physician. Many hospitals are setting up general practice clinics with the idea of providing this service. The development of such clinics involves arrangements with physicians for around-the-clock care by the employment of physicians, by rosters of physicians set up by voluntary efforts of medical staffs, or by contracts with M.D. corporations.

There has been a great increase in extended care facilities, both through private enterprise and the development of chains of nurs-

ing homes. There has also been an increase in the number of extended-care sections added to hospitals.

There has been a definite reduction of the in-patient loads in the hospitals. Greater attention has been paid to the length of the patient's stay and, as increases have taken place, procedures have been developed for home and ambulatory care.

A lessening of opposition among doctors against salaried employment by the hospital continues, thus making more of them full-fledged members of hospital organizations. Also a decided trend toward the integration of doctors in the top authority structure or board structure of hospital organization is noticeable.

Some private and more Federal funds are available for extended experimentation in regional planning and comprehensive health care. Ultimately these plans seem to be directed toward the development of community health complexes and health maintenance organizations. These organizations would provide complete care for members of the community who are willing to participate in types of comprehensive care on a continuing basis. Such plans would involve alliances between doctors of medicine and various health care and delivery institutions. These plans seem to involve the development of financial structures through which funds could be channeled from governmental sources to supplement or take the place of monies provided by individuals so as to make possible comprehensive care for all.

VI. THE FUTURE—THE 70's, 80's AND BEYOND

The development of comprehensive care for all people from birth until death suffers from a considerable time lag, in spite of the Federal government's commitment to it as a right for all people. It is very difficult to forecast when this aim can be realized to any great extent. A number of questions remain to be answered.

1. How much care will be needed?
2. What will the means of financing be? Will it be through national health insurance as a supplement channeled through present voluntary or commercial insurance? What will in-

dividuals pay in addition to taxes? To what extent will employers pay?

3. What are the detailed procedures and relationships?

4. What increases in physicians, physicians' assistants, nursing personnel, and administrative personnel would be needed?

5. Will there be a single health system highly socialized under the control of the Federal, state and local governments, resulting in the practical end of voluntary and proprietary involvement? Instead of the single system will we have a pluralistic system which uses the various organizations which we have had, but with overall coordinating structures? How will the overall coordinating structures be designed so as to avoid competition, overlapping facilities, development of unnecessary facilities, and at the same time bring about extension of health care into areas where health care is not now provided? What provisions will be made for joint purchasing and standardization of certain activities which will provide more economical health care?

6. What kind of alliances need to be made by doctors in private practice, dentists in private practice, and specialists of various kinds (psychiatrists among them), in order to bring this dream of comprehensive care to fruition? What kind of changes in the nature of our public health services? Will these services be further decentralized to the community health complexes that are being developed? Will such arrangements end the present conflict which exists between public health services and the hospitals?

7. Will technology, as it has in the past, advance so fast and so far that it will continue to outstrip the methods which are used for the distribution of care?

8. To the extent that the criticisms leveled at the present methods of providing health care are valid, what kind of adjustments must we, can we, and will we make in order to bring about the desired change? Will not the social adjustments by themselves need to be very great? What increased regi-

mentation of the lives of clergy, of doctors, dentists, nurses, administrators, proprietors of health care institutions, and consumers themselves is likely?

9. And finally, at what point will taxpayers and the other citizens begin to be willing to trade off some health care benefits for less regimentation and a reduction in taxes?

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Chapter Three

PASTORAL VISITATION OF THE SICK

Ralph J. Karl, O.M.I.

THE PARISH PRIEST AS PART-TIME CHAPLAIN

A parish priest in a hospital has always been a familiar figure as he went about his quiet way bringing Christ's consolation to the sick. In recent years, especially since the formation of the National Association of Catholic Chaplains, his status and prestige have taken on new and greater dimensions. The various hospital and professional associations have recognized the tremendous value of the priest's spiritual ministry in the total care of a patient.

Sickness seems to have a psychologically incapacitating effect on the total individual, depriving the patient of his sense of dignity, worth, and ultimately his desire to go on living. The patient, deprived of his physical strength and mental well being, experiences the fears and apprehensions which beset those who have lost the privacy and security of home and find themselves in a situation where they must depend on total strangers to accommodate their most personal needs. Religion plays an important part in the treatment of the patient because concepts, values, prayer, and ritual serve as motivating forces to assure the patient that, despite his limitations, he is still a worthwhile human being. Such reassurance has become an essential and new function of the hospital's health care team.

The parish priest as part-time chaplain is a member of the professional team. What follows applies to both full-time and part-time chaplains. His sacramental ministry and specialized skills, added to those of the physicians, nurses, social workers, therapists, and other paramedical and related personnel, help speed

the patient's return to health. His contribution is especially significant for patients facing major surgery or extended medical and psychiatric treatment, the chronically sick, and the terminally ill. The priest can help reawaken in these patients the faith needed to provide them with the measure of hope required to sustain their wills to struggle against incapacitation.

By his many years of training leading to ordination, the priest is exceptionally well qualified to care for the spiritual needs of the faithful. He gives unique devotion and care: gentle and kind understanding as he hears confessions; the presence of Christ Himself in Holy Communion or viaticum; the anointing of the more seriously ill to comfort them and give them the healing power and inner peace which come from the sacrament of the sick; encouraging and friendly words to the lonely, depressed, and aging; comfort for the families of the sick, especially at the time of crisis or death. The priest is another Christ, trying to preserve the life of the soul and afford spiritual comfort. The priest is by profession a man of God.

If, however, the priest is to be accepted as a professional and an integral part of the health team, he must recognize the responsibilities of the administration and professional staff. It is important that he meet with the Administrator and or Director of Nursing Services and together work out with them a satisfactory program for meeting the spiritual needs of the Catholic patients. Hospital administrators are anxious that this care be provided for their patients, but they must know what is going to be done and they want these services provided in an orderly manner so as not to interfere with the other procedures and routines of the hospital. It is unfortunate and indeed disastrous when an individual priest attempts to act independently from the structure. This is not the way to win the cooperation of the administration or staff; in the end the patient will be the one who loses.

PASTORAL GUIDELINES

In the past guidelines have been compiled by experienced chaplains which will be of practical value both to the priest beginning this ministry and also to the veteran as a means of updating his routine.

The parish priest should visit the hospital regularly. His visit

may give him the opportunity of establishing contact with persons who for many years have avoided priests or been fearful of them. A good number of Catholics return to the sacraments during a hospital confinement; the priest's visit can serve as the link between the sacraments received in the hospital and frequent reception of the sacraments when they return home.

The priest should check the admissions office for all of his parishioners. Word gets around the hospital that the parish priest has been in, and if the priest misses someone, the patient wonders why he has been passed by. Most hospitals gladly make available to all clergymen the admission lists, and it only takes a few minutes to check these cards either by town or by religious affiliation. Attention should also be given to patients from out of town.

The visitation of the sick is a fundamental pastoral office. The priest should never allow it to be reduced to a mere social call, much less degraded into a mechanical routine. Any impression of haste is completely out of place. Whether or not the sick person is to be anointed, the rites of prayer and reading from the Scripture should be celebrated with all present. The priest always brings the Word of God, the blessing and the sacraments.

Physical appearance and proper decorum can add much to the effective ministry of the priest. Styles which may be useful in working with certain groups (e.g., youth) would hinder the apostolate in health facilities. The image of the Church can be presented better if the priest dresses in modern attire while making his rounds.

The visiting priest should check at the nurses' station to see if the patient is available or can be seen. Often the nurse will be busy with the patient, but only for a short time. The ward clerk or the nurse will be glad to tell the priest how long it will be, or whether he can see the patient at all.

The priest should check as to the exact hours when A.M. care is being given. Patients at that time are being bathed or given other care by the nurses and his visits will hold up their work. At these hours the nurses are working on a pretty tight schedule. A visit can really throw them off and can lead to a request that the priest leave, without his understanding why.

The priest should always be careful to follow the hospital regulations regarding restricted areas. These areas have special problems and rules. The staff of these areas are the best guides to effective pastoral care. For example, the maternity area is out-of-bounds during the feeding periods. In some hospitals, visitors to the maternity floor will be asked to don a gown before entering the new mother's room. Visiting in psychiatric areas is normally restricted. The intensive care units are highly restricted to all as far as times of visits and length of time spent with the patient are concerned. Isolation or no smoking directives should not be ignored. They are only displayed when they are needed, and are to be honored at all times for the benefit of everyone. Whatever isolation techniques are in effect should be followed. The priest should be especially careful and circumspect in observing reverse precaution procedures. The nursing personnel will be most willing to be of any assistance in this area. With the new anointing rite which calls for one liberal anointing on the forehead and the palms, there should be no danger of contamination of the oil stock itself.

Upon entering the sick room, the priest should take special note of the surroundings. The presence or notable absence of cards or flowers will indicate something of the patient's social and emotional condition. Show concern for all the patients in the room, not only for the one you have come to visit. Regardless of their religion or condition, most patients appreciate a few words of encouragement from the visiting priest. Before leaving, offer a short prayer or give your priestly blessing to all who wish it, Catholic or non-Catholic. At times the priest's blessing is given so routinely that it is not a prayer at all. Possibly the patient would find it more profitable not to receive a quick blessing every time the priest visits, but rather to have a prayer offered with the priestly blessing as a conclusion.

Many of those who are ill find prayer to be one of the highest forms of reassurance. That man is privileged to talk with God is in itself spiritually strengthening. The priest can help the sick person pray by reciting acts of faith, hope and love or by reading formal prayers from a ritual or prayerbook. The priest may choose to offer a spontaneous prayer suited to the individual needs of the person. Such a prayer is very effective if the priest mentions the fears and worries that the sick person has just expressed and reassures him that, as God takes care of the birds of the air and the lilies of the field, so He will take care of him.

Many times the sick will express their anxieties to the priest and seek reassurance. The priest can help alleviate these fears and instill reassurance simply by listening and finding out exactly what is worrying the person. The experience of sharing his anxieties with someone will in itself have a soothing effect.

If the priest gives the impression that he is a very busy man and in a hurry, few patients will have the temerity to bother him with their problems. Yet although the priest must show that he is interested and has time for the sick of his parish, he cannot overstay his visit unless it is absolutely necessary. A long visit, particularly to a very sick person, can tire him out for the day or hold up some treatment he should receive. The priest must learn from experience and judge from circumstances when he can be of service and when it is time to leave.

False heartiness, jokes, loud laughter, etc., are out of place in the presence of the seriously ill. If a sick person makes a joke, it is usually the brave gesture of a gallant person and not necessarily an indication of lightheartedness. There is a tremendous difference between being cheerful and being a clown.

No matter how experienced the chaplain may be, no matter how many years he has served in this capacity, he should be constantly on guard not to make himself a pseudo-physician. His role is not to diagnose or offer medical opinion. He is the representative of Christ and the Church. He should be a very human and sympathetic person. If the sick person has doubts about the care being given or the person giving the care, the priest should not add to the doubt by condemning the doctor, the nurses, or the hospital staff. On the contrary, positive comments concerning the quality of care help build the patient's confidence and improve the image of the priest in the eyes of the hospital personnel. If the priest is told of mistreatment or neglect, he can inform the proper authorities of the complaint for their investigation. This should never be done in the presence of the sick person or in a public setting.

When visiting a hospitalized woman in a maternity or gynecology area, the priest should be circumspect in his questions. She may have undergone an emotional as well as physical trauma—e.g., abortion, hysterectomy. If there is a specific need for such information, the priest may ask the nurse or doctor when the visit is completed.

If there is a Catholic chaplain assigned to the hospital, it would be wise to alert him if a spiritual problem is bothering a patient so that he can be of assistance in your absence. The visiting priest should let the chaplain know if he has given any of the sacraments. Since the chaplain keeps records of the sacraments this can be important if the patient becomes critically ill or dies suddenly. Call the chaplain at any time if you think you have need of him. If the visiting priest experiences any difficulties during his visits, it is proper to let the chaplain know of them. The chaplain is there not only to assist the sick, but also to assist the priests who come to visit the sick.

There is no "ideal" time for the distribution of Holy Communion in a hospital setting. Each institution presents its own unique problems. These must be evaluated, preferably after consultation with the nursing office, to determine the best time. The patient's need should be the deciding factor. Many chaplains are now distributing Holy Communion just prior to the supper hour or at the close of evening visiting hours.

The geriatric floor is at times the loneliest area of the hospital. Visiting priests should never pass an opportunity to visit these sometimes forgotten people in the closing hours of their lives. Most families are faithful and regular in their visits, but many of the aged are alone and some are neglected by those who should care. The hours drag for these people day after day. A short visit by the priest is the highlight of an empty day and can raise them from the depths of despair. The visit may be difficult, but be assured it is one of the most important visits you will make during your whole priesthood. These people have a right to the priest's time and the comfort you give them. The concern we show them as persons, the love we extend to them in the name of Christ as His priests, will become for them one of the greatest sources of encouragement to accept the will of God during their confinement or as they approach death.

Priests with apostolic responsibility for nursing homes or homes for the aged could use the Rite of Anointing within Mass occasionally, followed by a luncheon or buffet. This is often an effective morale booster. If the priest is called upon to give the Sacrament of the Sick to an aged person who has become seriously ill, it is better to talk with the person and explain why he has come and

what the sacrament can do. The healing aspect of the Sacrament should always be emphasized except when death is imminent. The priest then can assist the person to accept death knowing that the Sacrament has not only brought forgiveness of all sins but also the temporal punishment due to sin.

With elderly sick persons, it is important to remember that their hearing is often impaired. Clarity of speech is more important than volume.

In the emergency unit, the priest should keep his ministrations to the patient as brief as possible so as not to interfere unduly with the medical procedures being carried out. He may observe from a distance, and move in at an opportune time to administer the sacraments or, if possible, wait until the emergency procedures have been completed. The medical and nursing staff will be most cooperative once they know that the priest is not going to interfere with their work. Usually the priest is summoned in an emergency before the family is notified. In these situations, when the family is on the way to the hospital, the priest should await their arrival in order to be of assistance to them in this time of trial. He can offer a unique comfort to these people by his presence and his reassurance that the patient has received the sacraments of the Church. If the situation warrants it, the priest may await their arrival before proceeding with the anointing.

The medical and nursing staff is always appreciative when the priest is present either to break the news of death to the family or to be on hand as the doctor informs them of this event. When the task falls to the priest, he should break the news in as simple and direct way as possible. His tact, prudence, compassion, and sympathy will speak more loudly to the bereaved than any words he may use. Sometimes it is best to let the family state the fact of death. This neutralizes the denial-mechanism which often causes rejection of such news from a third party. A workable approach is an implicative statement such as, "I have some bad news for you." After a shocked silence, one of the family will usually state the fact of death. Generally, it is good to let the bereaved vent their grief for a few minutes. The priest can say or do little, but his presence at this time reassures them that the patient has at least received all the spiritual help possible at this crucial point in his life.

When called to minister to a person who is apparently dead, the

priest does not confer the Anointing unless there is some doubt as to whether the person is truly dead. For the sake of the family, however, it is advisable to say prayers or read a Scripture passage over the body. The family being present, it is also desirable to say a prayer for the survivors at such a time.

CONCLUSION

In hospitals and health care facilities, the priest deals intimately with the lives and, therefore, the souls of men. This is his contribution; this is something a community values more than anyone can ever know, because by the very nature of his service and dedication he points to man's dignity, his value, his eternal destiny. This is his task—not as a member of a group but as an individual carrying the banner of Christ, the message of Christ, the doctrine of Christ, the charity of Christ to man. As Cardinal Cooke said to the members of the N.A.C.C. in Minneapolis at the 1969 convention banquet, "Your spiritual and humane work in the hospital apostolate is one of the glories of the Church in America."

Chapter Four

THE CATHOLIC CHAPLAIN AND HEALTH CARE

Ralph J. Karl, O.M.I. **Walter J. Smith, Ph.D.**

> "The joys and hopes, the griefs and anxieties of the men of this age, especially those who are poor, or in any way afflicted, these too are the joys, hopes, the griefs and anxieties of the followers of Christ. Indeed, nothing genuinely human fails to raise an echo in their hearts. Therefore, the Council focuses its attention on the world of men, the whole human family, along with the sum of those realities in the midst of which that family lives. It gazes upon the world which is the theater of man's history, and carries the marks of his energies, his tragedies and his triumphs; that world which the Christian sees as created and sustained by its Maker's love, fallen indeed into the bondage of sin, yet emancipated now by Christ."
>
> —*Vatican II, Constitution on the Church in the Modern World*

The Church's concern for those "in any way afflicted" has included the physically and mentally ill since the earliest times, and has motivated her to construct, staff, and maintain hospitals for their care. An important member of any hospital staff, genuinely recognized as such in recent years, is the chaplain.

The ministry of the hospital chaplain is best provided by priests who have received special training to equip themselves for this demanding yet most rewarding opportunity to serve the people of

God who are mentally, emotionally, physically or socially ill and handicapped. Individuals in an institutional setting, in addition to their primary illness, have the burden of being set apart from society. Special understanding of the relations among religious faith, illness, and emotional and mental conflicts is required for a truly helpful ministry to institutionalized persons.

A clergyman with specialized education and training in ministry to those in institutions is better able to understand and appreciate his own strengths and limitations, and, thus, to fit well into the health care setting. It is as important for a chaplain to know what not to do as it is to know what to do. The thousands of people who are away from their own homes and churches each year, either temporarily or permanently, in hospitals, homes for the retarded, etc., have their own peculiar needs to which only the properly prepared chaplain can effectively minister. Since the chaplain assumes the role of their pastor, he must have the personal, educational, and experiential qualifications to minister to their individual needs in an understanding manner.

The continuing need for well-qualified chaplains requires that they have specialized education and training to prepare them for this distinct ministry. This education and training must be under the guidance of experienced chaplain supervisors. Only such programs can prepare competent chaplains who will be able to give better service to patients and residents of health care facilities, promote greater inter-professional respect and cooperation, create better working relationships in the community between the clergy and other professions concerned with helping people, and have deeper insight into their own personality strengths, weaknesses, and resources.

The Chaplain's Job Description

In order to write a "job description" for a Catholic priest who is a chaplain in a hospital, the needs of the community for whom he is to be chaplain must first be determined, and, in addition, what the Church is attempting to say to, and do for this community must be thought out. Only then should an attempt be made to decide on the kind of person who will be able to fill such a position. Medical science, hospital care, and the Church itself have undergone vast changes in the past decade. Since these changes are still going on, it is obvious that the role of the hospital chaplain will not re-

main fixed or static, but must be a dynamic response to people's needs.

The passage from the Vatican Council II *Constitution on the Church in the Modern World* quoted at the beginning of this chapter is a reminder that a priest in any pastoral ministry, even though abounding in faith, love, and maturity, must conduct his ministry in contemporary society. His approach must be incarnational. "They cannot be of service to men if they remain as strangers to the life and conditions of men." (Vatican II, *Decree on the Ministry and Life of Priests*)

Sickness is not simply a condition of life. It embodies in the sick person the needful condition of all mankind. Christ is mankind's physician and the priest is His representative. Thus the care and cure of the sick are, even in this life, the tangible and actual realization of that which will be brought to fulfillment in the victory of the second coming of Christ.

As a consequence, any description of the work of a priest in hospital ministry must attempt to fuse the role of the man "called" and "sent" to speak to the world of the transcendent reality of God with the role of the professional hospital chaplain working with other professional persons as a member of a healing team—a fully human person, sensitive to all human needs.

POSITION DESCRIPTION—HOSPITAL CHAPLAIN

Job Summary and Purpose

The Catholic chaplain is directly responsible to the bishop of the diocese for providing pastoral care to the Catholic patients and staff of the hospital. His special concerns are the critically ill and/or dying patients and their families. He provides daily for the administration of the sacraments: Baptism, Penance, Eucharist, and the Anointing of the Sick. He is available on any appropriate occasion to celebrate Mass for patients and personnel. He provides around-the-clock coverage for all emergency calls. He also makes himself available to those in need of spiritual counseling and guidance. In a word, he is the representative of the Catholic Church to the hospital family.

Administratively, the chaplain is directly responsible to the chief executive officer of the hospital for observance of basic policies,

regulations, and procedures essential to proper functioning within the hospital. The priest-chaplain will not be required to perform any act or function contrary to the doctrine or practice of his Church. It is the responsibility of the chaplain to see that his program fits into the effort of the hospital to provide total patient care. This will require cooperation and flexibility in adjusting to the needs of the hospital program without sacrifice of religious principle.

Qualifications and Training

1. Graduation from an accredited college or university and from a recognized seminary.
2. Ordination to the priesthood and continuing ecclesiastical endorsement by the bishop of the diocese.
3. Experience: 3 years of satisfactory pastoral experience.
4. Membership in a professional association of chaplains such as the National Association of Catholic Chaplains.
5. Certification: as granted by the Department of Health Affairs, United States Catholic Conference.
6. Continuing education: constantly updates his professional skill and knowledge in those areas pertaining to the hospital apostolate by participation in chaplaincy training programs, seminars and workshops.
7. Participation in hospital and community conferences, discussions, and educational programs as requested, and as these pertain to the spiritual ministry and the care of the sick and dying.

Pastoral Responsibilities and Duties

In the fulfillment of his religious ministry to the patients and staff of the hospital, the chaplain:

1. Visits the sick as soon as possible after admission and informs them of the spiritual opportunities available within the hospital.
2. Gives particular care to those in special need; the seriously ill, preoperative and postoperative patients and the emotionally disturbed.
3. Assists families or relatives at the time of death of a patient or in other crises.
4. Provides opportunity for the reception of the Sacrament of Penance and frequent Holy Communion.

5. Administers the Sacrament of the Anointing of the Sick to those in need of and disposed toward this sacrament.

6. Is available for the Baptism of infants in the hospital and establishes procedures for the administration of this sacrament by well trained personnel.

7. Is available to administer the Sacrament of Confirmation and witness Marriage when the situation is appropriate.

8. Records information on the administration of the sacraments in the proper register and notifies the proper hospital personnel.

9. Celebrates Mass for patients and personnel at scheduled times.

10. Counsels patients and staff at times of crisis and in difficult situations.

11. Provides consultation to staff.

Administrative Responsibilities and Duties

The staff position of the chaplain shall be recognized on the organizational chart of the hospital as being directly responsible to the chief executive officer. Administratively, therefore, the chaplain:

1. Schedules and coordinates his activities in consultation with other members of the health care team.

2. Maintains statistical records, prepares a budget and purchases the necessary supplies for his program, and keeps records of all correspondence.

3. Participates in staff meetings and in the hospital orientation programs.

4. Provides periodic evaluations of religious activities, projects, programs and objectives.

5. Establishes procedures for notifying local clergy of the religious needs voiced by patients.

6. Addresses church and civic groups regarding his religious ministry when requested.

Educational Responsibilities and Duties

In addition to his religious and administrative duties, the chaplain is also a teacher. Therefore he:

1. Conducts in-service programs for hospital personnel in the spiritual needs of the sick and modern medical ethics.

2. May be responsible for pastoral care programs, seminars, workshops, and training opportunities for clergy and seminarians.

3. Conducts research which contributes to a more effective religious ministry to patients and personnel.

As mentioned before, the chaplain is a member of the healing team. A patient is not simply a body with some part or parts out of order, but a person, all of whose parts and aspects are integrated into a whole in such a way that when one part or aspect is not working properly, some or all of the rest are affected. Thus there is a need for "whole patient care." Not only the physician and the nurse, but also the psychologist, the social worker, the chaplain, the dietitian, and representatives of all other relevant services must be involved if all the needs of any particular patient are to be met.

Consequently, the chaplain must participate as a member of the healing team whose purpose it is to treat and, it is hoped, to cure the whole person. When complete healing is not possible, the chaplain tries to be of help in assisting the patient to accept the situation as it is, attempting to impart the faith, hope and courage, which will enable the person to face and cope with the unpleasant reality. Thus the chaplain must always focus on the ultimate worth of every individual, no matter what his limitations or handicaps.

In order to function effectively as a member of a healing team, the chaplain must maintain cooperative relationships with all the other departments of the hospital and with all members of the different disciplines which make up the hospital staff. It is his duty also to interpret to these other disciplines the contribution made by chaplain service to "whole patient care." Thus, he will acquaint the hospital personnel with his religious program, with the consolations of religion which he brings to patients, and explain to them how his ministry dovetails with theirs in the treatment of the "whole patient."

The chaplain also needs to remember that he is a member of the hospital organization, and so must fit his ministry into the overall hospital program. He must work with others and adjust his own ideas and attitudes where necessary, and where the sacrifice of religious and ethical principles is not involved. Hospital regulations, basic policies, and rules of procedure are followed as part of his responsibility as a member of the hospital staff.

Chapter Five

THE DEPARTMENT OF PASTORAL CARE

Roger M. Fortin **Jack Mullalley**

Spiritual care of the sick has been a part of Judeo-Christian tradition since the advent of healing institutions. The earliest "hospitals" and the practice of medicine were closely allied to religion. Frequently, the priest was also looked upon as a doctor, and the two professions were thought of as one.

As medicine and medical care developed over the centuries, hospitals and hospital care matched that progress. In that development, however, there evolved a growing obfuscation of the interrelatedness of medicine and religion. The hospital eventually became divorced from organized religion, and spiritual care was relegated to a minor role, alive primarily only in denominational hospitals.

Recent re-emphasis by psychosomatic medicine on the interrelatedness of spirit, mind and body has brought about the concept of "total patient care," a care which encompasses all facets of man's existence—physical, social, emotional, spiritual, and economic.

This renewed awareness of total patient care resulted in the "Statement on Hospital Chaplaincy" of the American Hospital Association, issued in May 1967, which reads in part:

> The American Hospital Association recognizes that chaplaincy programs are a necessary part of the hospital's provision for total patient care . . .[1]

[1] *Manual on Hospital Chaplaincy.* (Chicago, American Hospital Association, 1970.) page v.

Thus, spiritual care of the hospitalized patient became a mandate to the hospital's board of trustees. Responsibility, in turn, devolved upon the chief executive officer or administrator of the hospital to carry out this mandate for total patient care.

Traditionally, the responsibility for spiritual care was given to a chaplain, who generally functioned on an individual basis and whose official status was that of a sort of advisor to the administrator of the hospital.

More recently, the delivery of spiritual care has been formalized in many hospitals by the establishment of a department called the Department of Pastoral Care.[2] (Cf. Organization Chart)

Although such a formal structure is a relatively new development in Catholic hospitals, it has for some time been a part of non-Catholic and government hospitals.

The purposes of this Department of Pastoral Care, broadly speaking, are:

1. To give organizational responsibility for, as well as visibility and standing to, the spiritual aspects of total patient care;

2. To provide a formal channel of communication and cooperation, both within the hospital for the chaplain and his ministry, and also with the clergy of the community served by the hospital;

3. To provide the patient, his family and friends, his clergyman and the members of the health care team with professionally trained and competent chaplains as spiritual care resource-personnel; and

4. To encourage the professional development of the chaplain and other personnel of the department through continuing study and education.

STAFF

1. *Director.* The Department is under the leadership of a Director or Chairman responsible to a major administrative officer. The Director should also be one of the chaplains. A typical job summary of a Director includes responsibility for:

A. Organizing the general administration of the Department so that each patient may be assured of adequate access to its services;

[2] Other designations: Department of Religion, Department of Pastoral Services, Chaplaincy Services, Department of Spiritual Care, etc.

B. Coordinating the activities of the Department so as to promote and maintain harmonious relationships with other departments, the medical staff, and the general public;

C. Fulfilling managerial functions, such as attendance at administrative staff meetings, preparing a budget, reports and projections, serving on appropriate committees (e.g., Patient Care), etc.;

D. Participating in the hospital's educational programs, such as in-service and community programs; and

E. Supervising the work of the members of the Department, evaluating their performance and guiding their professional development.

2. *Chaplain.* The chaplain is a clergyman who has received formal education and training for his position, meeting the requirements of his particular denomination. He is responsible to and assists the Director of the Department of Pastoral Care in contributing to total patient care through spiritual ministry, and in constantly striving for ever-increasing excellence of service to patient, medical and hospital staffs, and the public. When the patient census reflects such a need, there should be salaried full-time and part-time chaplains representing the major religious traditions.

3. *Pastoral Visitors.* In many denominational hospitals, certain Sisters are designated as Sister-Visitors. In other hospitals, patient visiting may be done by trained volunteers, often called Lay Pastoral Visitors. In general, this visiting involves greeting the newly-admitted patient, a daily social visit, and performance of certain simple and helpful tasks for the patient and his family. Both the Sister-Visitors and the Lay-Visitors require formal orientation to this work, and such training is the responsibility of the Department of Pastoral Care. The extent and depth of the participation of these visitors in the spiritual care program of the Department will, obviously, vary according to the services which the hospital provides.

4. *Community Clergy.* The Department of Pastoral Care is responsible for all relationships of the hospital with the clergy of the community. The Department facilitates the services of the visiting clergy and interprets institutional policies and procedures to them. It often offers conferences and lectures to them to increase the effectiveness of their ministry to the sick.

5. *Trainees.* Many Departments offer training programs for various types of trainees—seminarians, clergymen, and other health professionals. These programs are aimed at developing and refining the pastoral skills involved in an effective ministry to the sick. Some programs are highly organized, offering stipends and a formal academic curriculum with supervision. Others are less structured, simply providing occasional lectures and consultation.

6. *Volunteers.* Some of the functions of the Department of Pastoral Care are carried by staff members drawn from the hospital's volunteer organization. Volunteers can perform a variety of services, such as: typing, filing, messenger details, organist, sacristan, transport service and bringing patients to chapel services, etc. Whatever the service performed, the Department usually undertakes the training and supervision of such volunteers, in consultation with the volunteer office.

MINISTRY

Programs of ministry vary from hospital to hospital. However, there are five major areas of concern with which all Departments of Pastoral Care must deal:

1. *The Patient.* The patient is the prime concern of the Department of Pastoral Care. Specifically, the Department, through its chaplains and other personnel, can identify the religious and emotional needs of the patient and help to meet them. More specifically, it assists the patient's orientation to institutional life and makes known to the patient the religious services available within the institution. It represents the religious community of the patient's faith, expressing its concern and care.

The Department provides a complete sacramental ministry, helps with prayer, distributes scriptural and devotional literature, and makes available trained and compassionate counselors. In essence, the Department tries to make the occasion of hospitalization a positive experience in the life of the patient.

2. *The Family.* Often, particularly when a patient is seriously or terminally ill, it is the family who bears the burden of tension, anxiety, fear and depression. The chaplain and other personnel of the Department of Pastoral Care assist the patient's family to cope with their own needs by pastoral support, advice, and coun-

seling. Hopefully, having resolved their own conflicts and tensions, they will be able to make a significant contribution to the welfare of the patient.

3. *Medical Staff.* The Department of Pastoral Care assists the physician in the development and implementation of the total patient care plan. It communicates facts relative to the patient's spiritual and emotional condition, and provides the trained expertise to deal with this facet of patient care. The Department also makes available professional consultation on medico-moral problems, and offers a personal ministry to the physician himself.

4. *Hospital Staff.* The Department of Pastoral Care participates in and cooperates with the hospital personnel in their delivery of total patient care. This cooperation involves periodic conferences with the hospital staff on the treatment of the patient. Often the patient's family, friends, and pastor participate as well.

In addition, the Department of Pastoral Care provides in-service educational programs for the hospital staff and students on the religious and emotional needs of the patient and the resources available to meet these needs. It assists the staff and students through conferences, seminars, visual-aids, literature, etc. It also provides counseling to help the members of the hospital staff deal with their own conflicts and problems, both personal and professional.

5. *Clergy and Community.* The Department of Pastoral Care assists the clergy of the community effectively to perform their pastoral role towards the sick and dying. In many hospitals the Department of Pastoral Care provides continuing professional educational programs on pastoral aspects of sickness and death, both for the clergyman and for his lay volunteers.

The ministry of the Department to the greater community may be in the form of varying levels of teaching, consultation, speaking engagements, liaison with the hospital, and research. Also, whenever possible, the Department offers out-patient services, usually in the area of pastoral counseling.

ESTABLISHMENT OF A DEPARTMENT

The establishment of a Department of Pastoral Care in a hospital is not lightly undertaken, and its establishment represents

the commitment of an institution to a continuing program of ever-expanding influence and ever-extending excellence. Some of the essential steps in establishing such a Department include:

1. *Presentation to the Governing Board.* When there is a need for such a Department, it must be presented to the board of trustees for approval. This usually is done by the chief executive officer or administrator, armed with pertinent statistics, current literature, and a firm personal conviction of the necessity of such a Department.

2. *Hiring the Director.* To attract candidates for the position of Director of the Department of Pastoral Care, national hospital organizations and ecclesiastical groups [3] can be most helpful in providing applicants. Naturally, questionnaires, statements of philosophies of applicants and their resumes are essential in the selection of the Director. It is most important that the administrator be allowed to accept or reject applicants, as well as have the freedom to negotiate the conditions of employment.

The Director finally selected should be a trained hospital chaplain with a firm commitment to the ministry to the sick and a thorough knowledge of the pastoral and organizational skills needed to function effectively within the hospital environment. He must, further, have the personality to be able to attract the clergy of the community to participate in the programs of the hospital, and to interact successfully with other health professionals. If it is anticipated that the hospital will initiate programs of supervised training of pastoral students, it is well that the Director also be certified as a supervisor by a nationally recognized certifying and accrediting organization.

3. *Conditions of Employment.* The Director should be paid the same salary, or its equivalent, as other department directors or chairmen. His duties and responsibilities should be clearly outlined in a formal job-description. The future development of the Department should be initially discussed and periodically reviewed and evaluated, and the formal and informal expectations of the hospital continually updated. Other conditions (office, professional and secretarial staff; budget, including projections for the future;

[3] For instance, the American Protestant Hospital Association, the National Association of Catholic Chaplains, the Jewish Welfare Board, the Catholic Hospital Association, the Association for Clinical Pastoral Education, etc.

vacation and educational needs; personnel policies; etc.) should be specified in a formal written contract.

4. *Clergy Meeting.* The clergy of the community should be invited to the hospital as part of the initiation of the Department. The hospital will thus have the opportunity to present its program and its Director, and to express its openness to the suggestions of the clergy of the community for the more effective functioning of the Department. In most hospitals, also, community clergy of different faith-groups are elected or appointed to a Pastoral Care Advisory Board to communicate to the hospital its suggestions and opinions.

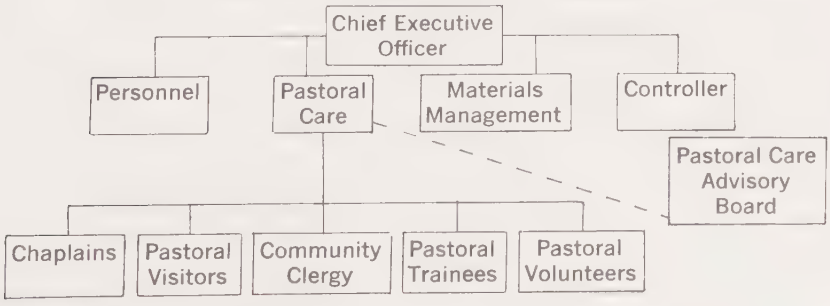
5. *In-House Meetings.* The Director should present his program and expectations to his professional associates—other department directors, the nursing staff, and the medical staff. He can tell them what he can do for them and their patients, and how they can help him by referrals, participation in his departmental programs, etc.

* * *

This description of the Department of Pastoral Care is necessarily broad and general. Hopefully, it will prove both informative and helpful. Informative, in that it depicts the philosophy and operations of most Departments as they now exist throughout the country. It should also prove helpful, both to a hospital planning to establish a Department of Pastoral Care and to a chaplain moving into the office of Director of a Department of Pastoral Care.

The contemporary American hospital is expending every effort to serve its patients better. The Department of Pastoral Care represents the latest refinement and development for the provision of spiritual care. It shows evidence of great expansion and extension. God willing, it will show growth in increasing effectiveness as well.

ORGANIZATION CHART (PARTIAL)



Chapter Six

THE CHAPLAIN IN THE MENTAL HOSPITAL

Thomas Forker

The mental hospital chaplaincy adds a new dimension to general hospital chaplaincy work. This is true of both the attitudes which the mental hospital chaplain must develop and the special skills he must learn in order to work successfully in the very different milieu of the mental hospital.

Attitude

Perhaps the hardest task for the priest entering this field is to develop a new attitude. From his background and training, as well as from the writings and sermons of many well-respected giants of the past, he may have developed some erroneous ideas about mental illness.

Many theological writers of the past have pictured the mentally ill as completely devoid of sensibility. While there are such patients, it is a mistake to think that the majority of those in a mental hospital are so disturbed that they cannot appreciate or understand things religious. Most patients in a mental hospital could wait in line for a bus or at a supermarket check-out counter without drawing any attention to themselves. The idea of patients "climbing the walls" must be put aside, it is not true. Especially with the advent of new drugs, all but very sick patients are well able to appreciate and participate in religious activities. The picture of the *furiose* and the *amentes* of the old theologians can no longer be considered completely valid.

Another group of writers considered mental illness as a sort of stubbornly held moral fault. This idea of mental illness was epitomized in the words of a famous priest: "If they would get on their knees in the confessional instead of on their backs on a psychiatrist's couch, they would be better off."

It may be that some outward expressions of mental illness correspond to problems seen in the confessional, but their etiology is completely different. The priest who tries to use moral tools to cure mental ills will do more harm than good.

The priest entering the mental hospital chaplaincy must realize that the mentally ill are just that—*ill.* They badly need the help that the psychiatrist can give them. Far from belittling or being jealous of the psychiatrist, the priest should thank God that psychiatry is developing as rapidly as it is. Many mentally ill people, whose condition would have gone unrecognized a few years ago, can now profit from an early diagnosis and a speedy recovery.

On the other hand, the chaplain should avoid the other extreme which sees in psychiatry the new "gospel," bringing peace and salvation to all the world. This view was held for a while by a few psychiatrists, but is now found only in a very new psychiatric resident. Most psychiatrists regard their field more as an "art" to be learned than as a science—a field with few specifics and frequently limited goals.

While the passing of the omnipotent priests of the past and of the Jehovah-complexed psychiatrists whom they faced, the "new breed" of both professions can cooperate better to help the patient. On his part, the priest will have to study hard in order to learn: (1) the vocabulary and history of the field; (2) its generally accepted possibilities; (3) the limitations of psychiatry.

In passing, it should be noted that the chaplain entering work in the mental hospital will find prevalent in most places the "team approach," in which the various disciplines cooperate, under the direction of the psychiatrist, to help the patient. The chaplain should be prudent and not let himself be swept along completely with this tide. If, as a "religious therapist," the chaplain allows religion to be merely another "tool" of the psychiatric team, there is real danger that religion will be valued solely for its curative utility and, if it fails to contribute to a cure, will be cast aside and its inherent spiritual worth discounted. The chaplain must always keep in mind that religion, both in and out of the hospital, has its own ends and is not to be considered merely as a tool for ends other than its own. Religion tries to bring God to man, and man to God; if it does this, it achieves its own end, even if the patient never recovers. The chaplain does have a place on the therapeutic team, and he should be as helpful to the other team members as

he can. But the chaplain's therapeutic role is limited, and his place on the team is on the bench, not on the field.

Finally, as far as attitude is concerned, the priest should keep in mind that he is at the mental hospital always and only as a man of religion. He was sent by his bishop to take care of the religious needs of the patients. He was requested and accepted by the hospital authorities for the same reason. His relationship with the patients will always be on this level. Only so long as he acts as a man of religion is he fulfilling his function. If he tries to step over into another field or work on another level, he will not only be less effective than those specially trained for those other fields, but he will seriously jeopardize his further effectiveness as a priest.

The mental hospital milieu will make small and subtle changes necessary as a priest carries out his work as a chaplain. Next we will consider the various functions which the priest will find himself performing.

The Mass

It would be difficult for a priest who has not been active in a mental hospital to appreciate how very desirable it is that patients be able to attend the Holy Sacrifice of the Mass as frequently as possible. Where patients have the opportunity to attend Mass and receive the sacraments, the priest will find a lively religious sense. Where they do not have this opportunity there will be almost complete apathy as far as things religious are concerned. Consequently, the chaplain should strive to make the Mass available to as many as possible.

The Mass on Sunday and holy days should be in a central place and scheduled at a time most convenient for all. If a chapel is not available, the assembly hall or another central location may be used. In making his schedule, the chaplain must take into consideration services of other denominations and the over-all schedule of the institution. Due to personnel problems, it may be necessary for the same group of attendants to accompany both Protestant and Catholic patients to services. If this is so, provision must be made in arranging the Mass schedule. In the mental hospital, much more than in other institutions, the chaplain will find it necessary to fit in with the over-all picture, because usually a small number of employees, in ratio to the patients, is expected to carry on the whole hospital activity.

Many experienced chaplains have found the use of volunteers to bring patients to Mass most productive. Volunteers can assist in bringing those who must travel in groups under supervision, and also those who need assistance—for example, those confined to wheelchairs.

No matter what the arrangements made to bring patients to a central place for Mass, there will always be a great number who will not be able to attend. The chaplain should try to take the Mass to them. This will entail making a survey of the hospital and its needs to find where the Mass will be available to the largest number. Such Masses should be considered in geriatric units and in units housing crippled and otherwise disabled patients. The chaplain should request permission from the Ordinary to use a portable altar.

The altars themselves are available from religious goods houses in a variety of easily transported units. The recent permissions to use the Greek Antemensium or Corporal make things even more convenient for the chaplain. It may be possible to leave a complete unit in an area where Mass is to be said regularly. After the staff sees the usual enthusiastic response on the part of the patients, the priest will be amazed at the cooperation he will receive from everyone.

In scheduling Masses, the chaplain should be sure to know and consider the regular routine of the institution. With the new rules on fasting, it should not be difficult to arrange Mass at a time that will not interfere with regular patient care.

Preaching

The central and ward Masses will provide the only opportunity that most patients have for things religious. Therefore, it is desirable that a sermon be preached at every Mass. One preaching in a mental hospital should recognize the special stress and anxious circumstances under which the patients live. It is well to avoid controversial or strictly theological subjects. Homilies on the liturgy of the day, from which a moral is drawn, are most useful. Since many patients are completely turned in upon themselves, talks on the Fatherhood of God and charity to neighbor are highly appropriate. Many of these people are burdened with feelings of guilt,

despair and self condemnation, and the sermon should not do anything to increase or seemingly endorse such feelings. The possibility of achieving heaven should frequently be stressed. The mental hospital is no place for fire and brimstone, but rather faith, hope and charity.

Devotions

Devotions, like all else, must be specially adjusted to fit the hospital routine and the needs of the patients. Many priests have found a weekly novena service desirable. Others feel that any devotions should be combined with the Mass. Benediction of the Blessed Sacrament is specially desired by many patients. (Permission for Benediction must be requested from the Ordinary.) Many experienced chaplains offer an annual retreat, whose length is adjusted to local conditions, and have found it very profitable. Film-strips portraying the Stations of the Cross and other religious subjects have been found most useful for ward services.

A word of warning is necessary about recitation of the Rosary in common. It should be supervised by the chaplain to make sure that it does not interfere with ward activity or become merely a showcase for the exhibitionist. The best approach is to keep groups small and have them retire to a secluded place when they say the Rosary together. This particular activity can arouse resentment in others unless properly supervised.

The chaplain should keep informed of any religious devotions being carried out by individuals or groups of Catholics, either on the wards or any other place in the hospital. Patients sometimes use seemingly good practices as a means of working out their mental problems, and the chaplain should be well aware of this. Frequently, more harm than good is done both to the individuals involved and to religion by such private or group devotions unless they are under the responsible leadership of the chaplain.

The Sacraments

In giving the sacraments to patients, the chaplain is doing something that he alone can do. Many other things that he is called on to do can be done by others. But only he can administer the sacraments.

Sometimes one hears the term "sacramentalism" used disparagingly by some of one's co-workers and even by non-Catholic

chaplains or professional people. Such name-calling should not cause one to neglect this very important part of the chaplaincy. Patients who have been negligent outside the hospital will look forward to receiving the sacraments in the hospital. Some will refuse, but most will be eager.

Even the "formalism" of the sacraments can be a key that opens the door to reality for some who have no other way of opening it. The very "rote" of the sacraments gives a sense of security to the patient in a mental hospital. When all else seems strange and new, this is one thing that remains constant. (As a matter of fact, the use of English and the new forms in the sacraments have to be introduced most carefully, because the people with whom the mental hospital chaplain is dealing find security in what is customary and usual.)

Penance

Through the sacrament of penance the priest can bring much solace to patients. But he must be on his guard, for he will come under the closest scrutiny from the dynamically oriented psychiatrists and may even meet outright opposition from some who do not properly understand the sacrament. If such opposition should arise, the chaplain might try to explain the mechanics of the sacrament, emphasizing its freedom, its secrecy, and what it deals with —normal guilt, not neurotic guilt. However, the priest should understand that a situation can legitimately arise in which a well-instructed doctor of good will may conclude that it would be best for the time being if a patient did not go to confession. In such a case, the priest should be willing to explain to the patient that such a request by the doctor is to be obeyed. For the most part, even doctors who do not completely understand the sacrament are most impressed by the obvious comfort it affords the Catholic patient.

In dealing with the sacrament, the priest has to consider both mechanical problems and those of a psychological nature.

On the mechanical side, there are two general ways of hearing confessions. The first is to bring patients to a central place where confessions are heard. In these days of the open hospital, weekly confessions at the chaplain's office or at the chapel, if one is available, will enable a great number of patients to go to confession regularly, as they would in their home parishes. In addition, it may be possible for the chaplain to arrange to have outside priests help

with confessions, at least before major feasts. This will provide a "copia confessariorum" which is most desirable. It is probably the most convenient method of hearing confessions.

However, the priest should not neglect the second (and more troublesome) method: going to the various buildings and wards in which the patients reside and hearing confessions there. This is an absolute necessity, of course, so far as bed patients are concerned. But it is also very productive in the whole hospital. There are many patients who will not go to a central place because of their general anxiety. There are other patients whom the ward personnel might not readily allow to go to a central place for confession, but about whom the priest can make his own decision if he visits the patients' building or ward. If convenient, the priest might visit the building during the week before confession time, both to observe for himself those who may be able to go to confession and by his presence encourage them to approach the sacrament.

On the physical side, almost any room can be used which is clean and affords privacy. A trefoil hospital screen with a crucifix hung on the patient's side can provide a confessional. An attendant outside the door keeps a list of names. The priest hears the confession, and if he feels that the patient is to go to Holy Communion he gives the patient a small slip of paper to give to the attendant. This says nothing about the patient's confession but merely tells the attendant whether or not to send the patient to Communion.

During the confession, the priest may encounter patients in poor contact with reality, poorly instructed Catholics who have never received Holy Communion, or people so emotionally upset that it might be best for them not to receive the sacraments at the present time. All these cases are covered by not giving the patient a slip of paper. The patient's confession is inviolate, and the attendant knows no more than is necessary.

On the psychological side, several questions should be considered. The priest will sometimes meet a patient who is in good contact with reality but has an obstacle to the reception of the sacraments (e.g., a marriage problem). The priest should explain the situation to the individual and invite the patient to speak to him outside the confessional about the matter.

In other cases the priest will find sufficient contact with reality, but will have difficulty in getting confessional matter. A statement

of sorrow for past sins would seem to be sufficient in these circumstances. This is similar to the case of hearing the confession of a person with a language difficulty or a deaf-mute. The difficulty of mental patients is frequently the same—a difficulty of communication.

In difficult cases the priest may ask, "Would you like to receive Holy Communion tomorrow?" Then he may ask, "What is Communion?" If any appreciation of the sacrament of the Eucharist is shown (such was asked by Pope Pius X in the case of children), the priest has an additional reason for allowing the patient to receive Communion.

The priest in a mental hospital has special problems found but rarely in the ordinary parish. The imputability of compulsive behavior is one. Much has recently been written about this subject. However, while it is important for the chaplain to know what the theologians say, they do not offer solutions for practical problems. The chaplain hearing confessions merely follows the rule of "believing the penitent both accusing and excusing." He accepts the matter as the patient confesses it. Take the case of the compulsive masturbator (i.e., obsessive-compulsive disorder), either male or female. It will be found that the patient has already made some sort of adjustment to the problem or else he would not come to confession. Frequently, he will not mention it; indeed, he may not even be aware of the frequency of the act. Again, he will refer to it with the statement, "I can't help it." In any case, the confessor is to accept it as the patient tells it. The confessor should avoid saying anything which would add to the burden the patient is already carrying. He should try to give encouragement to continued effort. The confessor who is a kind *Father* will do more good than the stern judge. A kind word may lift the penitent away from the depths of depression, and the grace of the sacrament will have the opportunity to strengthen him. It is good to remember that for all practical purposes it is the grace of God that can help such a person. Psychiatrists, at present, are completely without solutions for such compulsive behavior.

The chaplain new to mental hospital work must become accustomed to many differences from "the way things were in the parish." Nowhere else is the personal relationship between priest and penitent so important. Nowhere else is the priest so much the

property of his people. Nowhere else will the priest have a greater opportunity to live up to his name of "Father."

Patients will frequently insist on identifying themselves in confession. Even though a screen has been set up to protect his privacy, a patient may go around the screen and shake hands with the priest, both to identify himself and also to assure himself that "his" priest is there. Outside the hospital, the priest might send such a penitent to another confessional. In the hospital, however, any harsh action will drive the patient away from the sacrament completely and cut him off from what is perhaps one of the strongest helps on his road to recovery. For this reason the priest should be constantly aware of the latest trends in moral theology and any relaxation of previous judgments on the *recidivi* and *consuetudenarii.*

Many recent writers have stated that the majority of the mentally ill are not responsible for their actions. Such men may have done much reading about mental illness, but they have had very little practical experience. The priest in the mental hospital is constantly being surprised at the keen moral sense evidenced by the great majority of people who are mentally ill. The mentally ill person *may* bring into confession hallucinations; but 90 percent of the mentally ill patients who desire to approach the sacrament of penance will do so most worthily. Their confessions, as well as their lives, can be a lesson to many outside of the mental hospital. There may be problems of compulsive behavior. There may be confusion about other things. But the very comfortable feeling that pervades the patient when he starts off with the familiar phrase, "Bless me, Father, for I have sinned. . . ." will, for the most part, guarantee a good confession. Frequently it will be the first step on the road to normality.

Anointing of the Sick

The mental hospital chaplain will be called upon frequently to give the Sacrament of the Sick to those under his care. The population of the mental hospitals is growing progressively older, both because of the aging of those in the hospitals and because of the practice in many places of using mental hospitals to care for those for whom there are no other facilities. Since the problems of the aging are covered in a later chapter on the administration of the sacraments, it suffices here to stress only a few points. First, the

mental hospital chaplain frequently encounters persons with long-term chronic conditions who probably will stay in the hospital until they die. This is opposed to the general hospital situation in which the stay is comparatively short. It might therefore be useful to consider the practice adopted by many experienced chaplains of giving the Sacrament of the Sick to all past a certain age, e.g., to those 70 years of age or over. This practice considers advanced age as a physical cause of death. It has the advantage of enabling patients to receive the sacrament while still alive and conscious, rather than receiving it conditionally after a sudden death.

Repeating the sacrament at definite intervals might also be considered. This is important, since many of the extremely old are not in sufficient contact with reality to receive any other sacraments. Some will argue that there is no obligation to repeat the sacrament while the same danger of death perdures. But there are also theological authorities who would consider it a new "danger of death" if the condition continues for a long time. They would allow the sacrament to be repeated after a period of one to three months. Each priest will have to decide this matter for himself, but it does seem charitable to give aging people every chance to receive the grace of the sacrament.

Confirmation

The chaplain in the mental hospital has an obligation to see to it that those under his charge are prepared for and given the opportunity of receiving the sacrament of confirmation. This will happen for the most part in institutions caring for children, but will also apply to adults who have neglected to receive the sacrament.

Other considerations concerning the sacrament may be found in the chapter on "Administration of the Sacraments."

Baptism

In mental hospitals, the sacrament of baptism will probably be given only to children who are born in the hospital. Since baptism is a parochial function, the local pastor should be consulted as to his wishes in the matter, at least if no directive has been given by the bishop. Of course, in an emergency there is no question that the chaplain or any other person may baptize. If baptism can be administered or at least recorded in the local parish, it will be of

benefit to the persons involved when in later years they need a baptismal certificate.

Many states have regulations forbidding proselityzing by chaplains in mental hospitals. These regulations are frequently interpreted to forbid a mental hospital patient to change his religion while in a state institution. To a new chaplain, this might seem to work a hardship on individuals, but longer experience will bring most chaplains to agree with the regulations. Very often the person who wishes to change his religion under the stress of his illness forgets the idea completely when he recovers. On the other hand, if the desire to change one's religion persists, the patient can be instructed and baptized after release.

Marriage

The question of marriage in a mental hospital has been left to the last in this treatment of the sacraments, and the advice here is a strong *DON'T*. Patients are usually satisfied with the explanation that it is impossible to arrange a marriage while in the hospital. More difficulty arises with requests for assistance from parish priests or chancery officials trying to arrange or validate a marriage in which one of the parties is a patient in a mental hospital. In such a case, it would be wise for the chaplain to advise strongly against taking any action in regard to marriage while one party is a patient. From a canonical point of view, it seems foolish to build into a marriage grounds for attacking it in the future because of recognized mental illness. In any case, no action should be taken by the chaplain except under the express direction of the chancery.

Records

It is possible for the chaplain to be overwhelmed with records if he keeps too many. On the other hand, the chaplain who keeps no records cannot substantiate any statements about his activities. A happy medium is necessary. Certainly, records of baptisms, confirmations, anointings and burials must be kept. Most chaplains also keep a running log of their activities, which enables them to fill out various reports required by state and ecclesiastical authorities.

It is also strongly recommended that when the chaplain interviews or counsels a patient he make a record of the salient fea-

tures of the interview on a 3x5 file card. Future interviews can be noted on the same card and a running record will thus be available.

Interviews and Counseling

The chaplain in the mental hospital is called on to do much more interviewing and counseling than chaplains in any other field, except prison chaplains. Since the technique of counseling and some forms of psychotherapy are quite similar, the chaplain should bear in mind that his prime duty in the hospital is to deal with matters religious and moral. It may happen that in moral matters there will be a "therapeutic overflow." This is a fine bonus when it occurs. But the chaplain's function is not primarily to deal with the patient's mental illness. Counseling which has *only* therapeutic ends is not the proper field for the mental hospital chaplain.

The Admission Interview

The chaplain's first meeting with the patient will be at the admission interview, which should be conducted as soon as possible after the patient has entered the hospital. The purpose of this interview is merely to let the chaplain know who the Catholic patients are, and to let the patients know that there is a priest available in the hospital.

Experience will teach the chaplain how little talking and questioning are actually necessary to produce the best results. Before the interview, the priest should try to get as much information as possible about the patient from the records. He should know his or her name, age, marital status and other basic information before he goes into the interview. This will make it unnecessary for him to appear to be asking too many questions. The patient has been asked questions by so many people that he may rebel at another probing. The chaplain should merely introduce himself and perhaps ask the name of the parish to which the patient belongs. (It will be most useful if the chaplain tries to learn the names of the pastors and priests of the various parishes from which the hospital draws its patients. This will enable him to say, "Oh, St. Anne's—and how's my friend Father Jones?" Such an approach, or any other which puts matters on the level of a Catholic talking to a priest, will unlock many doors, and cause an outpouring from many a person who has just been waiting for the opportunity or the courage to speak to a priest.)

The chaplain will find that he has an advantage over every other person on the hospital staff. Others must go to great lengths to establish rapport with the patient. The priest's rapport has been established by every other priest with whom the patient has dealt since childhood. In this stress situation, the patient will almost reach—figuratively and sometimes even actually—to the priest as a source of strength and consolation. To emphasize that fact that he is a priest, the chaplain should always wear clerical garb; he should, if possible, avoid white jackets or other uniforms which might cause his role to be mistaken. Wearing a Holy Name or Knights of Columbus emblem can also help to further reassure a frightened and suspicious patient.

Though the interview should not be too long, during it the priest should try to convey the idea that he can act only in religious matters and has nothing to say about who enters and leaves the hospital or about the treatment of patients. By insisting on these points the chaplain may avoid problems later when the patient or his family try to pressure him to help obtain the patient's discharge, transfer to other wards, or change of treatment. The priest should never let the patient speak to him under the mistaken impression that he is addressing a doctor. This mistake is sometimes made.

In subsequent interviews, the chaplain should conduct himself in much the same manner. He will find that patients who were accustomed to talking to priests outside the hospital will also feel most at ease with the priest in the hospital. Sometimes his advice will be sought by non-Catholics. While he should be as pleasant as possible on such occasions, he should be careful to avoid giving the appearance of proselityzing.

Counseling

In counseling the chaplain tries to assist the patient in solving some of the matters discovered in the interviews. Priests have been helping people solve problems for centuries. They can be ranked among the earliest counselors. However, in recent years counseling has developed greatly and is now a recognized field of activity with its own specialized terminology. To be done properly, it requires a course of training. If the priest can obtain such training, he should do so, for it will enable him to deal more effectively with patients.

The techniques of counseling must be specially tailored for use by the chaplain, however, since he has his own special ends, as well as tools not available to others.

The end the chaplain seeks in counseling—as in every other activity he performs—is the moral and religious good of the patient. He should always limit himself to the religious problems of the patient and should not inject himself into the broader field of the patient's mental sickness.

Because of his specialized problems, the chaplain frequently cannot use the non-directive, non-judgmental approach of other counselors. Indeed, many of the problems the priest faces allow only a didactic, authoritarian solution. For example, the question of the validity of a marriage demands a judgment, followed by direction to solve the problem.

Other matters will not be so evident and will require longer investigation before even the basic problem is recognized. In any case, the chaplain can learn much from the field of counseling in his approach to those who need help. When the priest must point out a fault which needs correcting, he should do so with greatest charity. The sin—if there is one—is not against himself, and he should not assume an attitude of personal injury or resentment.

The chaplain cannot in the final analysis adopt a nonjudgmental attitude, for then the patient might make the mistake of thinking that the priest approves what is wrong. Counseling has been described as "structured listening." It will be much better for the priest merely to listen at first, restraining the urge to point out faults until he is sure that he has the complete picture. At this point, it will probably be unnecessary to indicate the fault, for the patient may well see it himself, and will need the help of the chaplain only to make the necessary effort to correct it.

It is frequently difficult for people to talk to priests, not because of bad will but because of a poor vocabulary. Frequently, the only term a patient knows to describe something is a four-letter word thought of as "bad." If the true picture is to emerge, the priest should encourage the patient to use the words he knows. He should certainly not take exception to vulgar words or show rejection of the patient for using them.

In counseling the patient, the priest has all the tools of the regular counselor. In addition, he has religious tools and motiva-

tions which are not available to others. Even the very natural tool of an even and pleasant disposition should be developed. The priest should point out, in-season and out-of-season, that the patient is the child of a loving Father, God, Who wants him to be healthy and happy here and for all eternity. This is especially necessary with mental patients who are frequently convinced of their own worthlessness. The priest should never be shy in using the strength of religion. On the other hand, he should not be a dealer in pious platitudes that mean nothing and are frequently not meant by the one who employs them.

In choosing the ends towards which he will direct his efforts in counseling, the priest will be wise to select a restricted, proximate and possible goal, rather than dissipate his efforts by trying for too much. Encourage a person who has been away from the sacraments to approach them; direct a person full of hate to pray at least for the eternal salvation of those hated. The objective (and it is better not to state it to the patient) will color and shape counseling. Success is more likely if the goal is pointed and sharp.

Relationship of the Chaplain to those with whom he works

In dealing with the medical and professional staff of the hospital, the chaplain should realize that patients come to the hospital for medical and psychiatric care, not to attend a mission or a retreat. Consequently, the priest should not be surprised if he has to conform to the medical routine of the hospital, rather than vice versa. He will have to accept the direction and decisions of the medical directors, who, it should be noted, will often go out of their way to respect the religious sensibilities of the patients. They will gladly listen to the chaplain's suggestions, but they will not accept his orders.

The hospital has the right to expect loyalty from the chaplain, and for this reason the chaplain should do all in his power to protect the good name of the hospital. He should report things that need correction to the authorities, but he should never carry hospital problems outside the hospital. Especially, he should not allow himself to be a source of information for journalists seeking scoops. In an extreme case, where a serious wrong has been reported but not corrected, he should discuss the matter with his Ordinary before presuming to take other action.

To the patients the chaplain is their priest. He should be very

careful not to be used as a weapon against a doctor by a patient or a patient's family. He should not allow himself to be drawn into matters where he has no authority or competency. It is more important to be careful of this in the mental than in the general hospital because the mental patient frequently derives a perverse pleasure from sowing such discords. "I am the priest and as such will do all that I can for you"—these should be the priest's opening words to the patient and this should be his continuing policy.

COMMUNITY MENTAL HEALTH CLINICS

The program of comprehensive community mental health clinics being fostered by the Federal government through the National Institute of Mental Health will change the concept of the chaplain's tasks drastically.

According to this program the patient will remain at home in his local community instead of being brought to a central hospital. He will continue his regular occupation, as far as possible, and will come to the community clinic for such services as he needs. The clinic will provide day and or night hospital facilities, counseling and individual or group psychotherapy, crisis-intervention services, and, where necessary, short-term hospitalization.

Since he will be living at home, some of the patient's religious needs will be taken care of by his regular parish clergy. An institutional chaplain will not have to provide these services. However, the staffing plans for most comprehensive community mental health clinics do make provision for a chaplain in their table of organization.

The task of such a chaplain would be very different from that of the chaplain in most other health institutions. They would be for the most part those of a pastoral counselor, but may include roles of liaison-officer, educational resources officer, and public relations person with the local religious community.

In his capacity as liaison between the clinic and the clergy of the community the chaplain would be expected to explain the ideas behind the community approach. He would enlist the interest of local clergy in the work of the clinic and would encourage them to refer parishioners to the clinic.

This might be best carried out by the chaplain acting as an educational resource person. He might sponsor community clergy days to help clergymen recognize mental illness, and explain the steps to be taken to refer a case to the clinic.

In addition, the local clergy might be encouraged to become actively interested in the work of the clinic, both as members of the clinic team and as persons to whom the clinic staff could refer patients for supportive help.

All of these things would demand a close and continuing relationship between the chaplain and the local clergy. The chaplain would actively seek out opportunities to speak to various religious groups, both clerical and lay. He would be available to local clergy who might have need for help in special cases. Finally, he would be available to the local clinic therapeutic treatment team when a matter with deep religious involvement arose in a particular case.

Chapter Seven

PASTORAL MINISTRY TO THE MENTALLY RETARDED

Ralph J. Karl, O.M.I.

"Mental retardation" covers many different manifestations of arrested brain development accompanied by difficulties in regard to one or more of the following: (1) maturation, (2) learning, (3) social adjustment. The mentally retarded person can be of any physical age; but his mental age and ability for self control determine his actions and responsibilities.

The mental age of a person is determined by intelligent quotient (IQ) tests administered by a competent psychiatrist or psychologist. According to the system used in institutions today, there are three main classifications. Persons with an IQ of zero to 25 are considered *custodial* (profoundly—severely retarded). They must be treated as children who need constant supervision. They do respond to habit formation and regular physical activity, but may never learn self-care skills. Persons with an IQ of 25 to 50 are considered *trainable* (moderately retarded). They can learn simple communication, elementary health and safety habits, and simple manual skills but do not progress in functional reading or arithmetic. The trainable can travel in the institution or under supervision to neighborhood areas and can perform many useful tasks in the home or sheltered workshops. Persons with an IQ of 50 to 75 are considered *educable* (mildly retarded). Although limited in their potential for academic achievement, they can acquire social and vocational skills adequate to self-maintenance.

The population of state institutions and residential facilities includes persons from all three classifications. It is unrealistic to believe that all will have the same mental achievement or ability to

learn. Persons are unique. This fact will pose several problems for the chaplain as he provides a sacramental ministry for his parishioners.

Are the mentally retarded able to receive the sacraments? Unfortunately commentators on Canon Law and moral theologians have not established definite norms for the mentally retarded. However, Dominic Prummer, O.P., in his *Handbook of Moral Theology* gives two definite principles concerning the obligation of administering or refusing the sacraments. First, "those who have the care of souls in virtue of their office are bound in justice to administer the sacraments to those who reasonably request them; other ministers have an obligation in charity." Second, "the sacraments must always be refused to those who are not capable of receiving them, who would receive them not only unlawfully but also invalidly; one may not administer the sacraments to those who although capable of receiving them are unworthy to do so, unless there is a grave cause." It seems that the chaplain is obligated to administer the sacraments to persons capable of receiving them worthily. A "capable" person is one who has the use of reason, necessary intention and sufficient instruction.

How do we apply these conditions to a retardate who has limited ability to understand the truths of faith and to elicit a proper intention? An important phrase is "the use of reason." This term refers to the degree of intellectual maturity necessary to make a moral judgment—to distinguish right from wrong and know that good is to be done and evil avoided. Traditionally, a child of the chronological age of seven was presumed to have reached the age of reason. Modern theologians have disputed the traditional view, stating that the mental age of the child is more important than the chronological age. It has been left to the parents and pastor to allow the child to receive the sacraments when they judge him to be mentally ready. If a retardate has the mental ability to form a moral judgment, then the parents and chaplain may consider him ready to receive the sacraments. From this we can see the importance of considering mental age rather than chronological age.

In considering the phrase "sufficient instruction" it must be determined what is minimally sufficient for the retarded person according to his state in life. The basic truths should be known, i.e., that God exists, that God rewards good and punishes evil, that there are three divine persons in God, and that God the Son became

man to redeem us. In addition to these beliefs the person should have some knowledge of the sacrament to be received. The retardate should be judged according to his ability and not by the mental ability of the normal child.

Whether or not a person has the "necessary intention" can be determined by his request for the sacrament or by his behavior at prayer, by his behavior in church and by his attitude toward God. The retarded person tries to imitate other children and adults. When he sees others receiving the sacraments, he has the same desire. Simply stated, the "necessary intention" for the retarded is the desire to know, love and serve God and do all things necessary to be a child of God.

Guidelines for Administering The Sacraments

Baptism The retardate who has not attained the use of reason will be baptized as an infant. The retardate who is capable, i.e., has the use of reason to some measurable degree, may be admitted to the Sacrament as an adult. The additional conditions, such as proper intention, desire to receive the Sacrament of Baptism, and sufficient instruction, must be modified and interpreted according to his mental ability. The chaplain may be the judge of what the Church requires of these persons.

Confirmation In recent years many Ordinaries have allowed the administration of Confirmation to retardates, dispensing them from the usual conditions of age and instruction. Application of the double principle that sufficient instruction is required only when the candidate has the use of reason and that the Sacrament can be administered before the age of seven for a just and serious reason has made many retardates eligible for this Sacrament. Thus many retardates, who could otherwise never have hoped to receive the infusion of the Holy Spirit and the gifts promised by the Church, may now do so. The chaplain should establish a routine cycle for the administration of Confirmation by the bishop. Such a program gives the parents of the retardates much happiness, especially if they realize that their child may never receive Holy Communion or any other sacrament.

Holy Communion The Church's present law gives positive norms and guiding principles for the reception of Holy Communion by children. According to canon 853: "Any baptized person who is not forbidden by law may and must be admitted to

Holy Communion." This canon states the basic right of every individual to receive Holy Communion. Canon 854 explains the phrase, "who is not forbidden by law," in this way: "Children who by reason of their age have not yet a knowledge of and a desire for this Sacrament should not be given Holy Communion." Canon 854 #2 decrees: "In danger of death Holy Communion may and must be given to children as long as they are able to distinguish the Holy Eucharist from ordinary bread and reverently adore it." Outside of the danger of death, a fuller understanding of Christian doctrine and a more careful preparation are required, as Canon 854 #3 states: "Children, in so far as their capacity allows, must be acquainted with at least the mysteries of faith which are necessary as absolute means of salvation and they must approach Holy Communion with such devotion as can be expected from young children."

The chaplain will often be asked by pious parents, "When may my child make his First Holy Communion?" For this reason the above canons are quoted by the Rev. Gerard Breitenbeck, C.SS.R., in the pamphlet *"May The Retarded Receive Communion?"* which should be obligatory reading for a chaplain to the mentally retarded. The chaplain must determine if the child may or may not receive Holy Communion. Does the person have the mental ability, the necessary intention, and sufficient instruction? The Rev. Aloysius J. Heeg, S.J., commenting on the decree *Quam Singulari* of Pope St. Pius X, answers these questions by saying: "A point in the decree that many overlook is this: The child should be prepared for his First Communion in such a way that he may come to the Eucharist with a devotion proportionate to his years. . . . By all means, let us make the instruction of the little child as thorough as possible, but in doing so let it be in the words of St. Pius X, 'according to his capacity'. When we think of the capacity of the child, let us not forget that besides a head he has a heart and that besides knowing he must love." To determine if the retardate has the proper intention, the chaplain should ask, "Why do you want to receive Holy Communion?" If he answers, "To receive Jesus" he certainly has the right motive and should be admitted to the Sacrament.

Once the person has made his First Communion, the chaplain should continue instruction either in general classes or in sermons during the year. Supervision and patience are necessary to make

the reception of the Sacrament meaningful and enjoyable. For some it will be necessary to provide them with a sip of water to help them to swallow the consecrated Host. It is not unusual to give a retardate Communion and then observe him until the Host has been chewed and swallowed. Experience will dictate what steps the Chaplain should take.

Penance The retardate receiving the Sacrament of Penance sometimes causes a dilemma for the confessor. The absolute minimum must be demanded of the retardate in confession, since only the most obvious sins will be remembered and admitted. Usually the confessor must resort to asking questions in order to determine whether sufficient matter exists. Whenever matter appears insufficient, the individual may be given a blessing with a short "ferverino."

The place and circumstances are important to consider when retardates go to confession. It is advisable to hear confessions in the office or sacristy or to have a light placed on the penitent's side of the confessional. Many retardates are afraid of the dark and in some instances it will be necessary for the confessor to see the person nod yes or no to questions. The chaplain should establish a simple yet complete format to be used as a standard. Constant repetition will give the retarded confidence in going to confession and will encourage him to receive this Sacrament frequently.

Whenever a group of persons are scheduled for confession the chaplain or teacher may read an examination of conscience specifically designed for children. After going through the commandments, the one who presides may lead the group in an "Act of Contrition." After all have made their private confession the leader may say a few appropriate prayers which may suffice for the sacramental penance. The "Act of Contrition" may be, "O my God, I am sorry for all my sins because they displease you, who are all good and deserving of all my love. With Your help I will sin no more." For the trainable retardate the prayer, "Jesus, I am sorry, I will try to be a good boy (girl)" will suffice.

The Sacrament of Anointing of the Sick The Sacrament of Anointing of the Sick should be administered unconditionally to those retardates judged capable of committing sin, even venial sin, whether or not the person has received the Sacraments of Holy Communion and Penance. It should be given conditionally when-

ever the chaplain has some doubt as to whether the person has reached the age of reason.

If the retardate is conscious, suitable prayers should be said so that he realizes that the chaplain is there to assist him in every spiritual way. Because of fear the retardate will need this assurance. Emphasis should be placed on the idea that Jesus loves him, will care for him, and will help him.

Matrimony Some chaplains might disagree with administering the Sacrament of Matrimony to the retarded, but they should consider the fact that, although retardates are mentally arrested, their physical needs are the same as their chronological age. Because of television, movies, and magazines promoting sex and marriage, it is no wonder that retardates want to be like their parents and "normal" persons and enjoy the same comforts and privileges that a "home" could provide.

A few of the educable can have financial security (especially with federal, state or community assistance) and can provide a home. The chaplain should point out the difficulties and give abundant instruction so that they are prepared for their responsibilities. If the retardates are determined, they will marry either with or without the assistance of the chaplain. The institutional chaplain may not face this difficulty, but some priests will.

Religious Education The sacramental ministry of the chaplain is not complete without a program of religious education. One is not possible without the other. The chaplain is a teacher responsible for instructing the retardates in principles of religion, proper moral action, and socially acceptable behavior. Because of the three separate types of retardates, the chaplain must adapt his lessons to suit the mentality of the persons in the class.

The retardate must be taught at his pace, in terms he can understand, and with patient, loving care. Should one of these be lacking, the retardate could become surly, unruly, boisterous or rebellious. The learning disabilities of retardates are evident in their short attention span, reduced ability to comprehend abstract principles, and limited vocabulary. Some have an extremely difficult time writing, copying or exercising other motor skills due to cerebral dominance or organic brain damage. The retardate can-

not understand his handicap and this generally leads to personality conflicts, insecurity, dissatisfaction, and finally frustration.

Teaching the retarded is one of the most difficult undertakings in the world, if the pupils' characteristics are not known and understood. But once the chaplain has tried, made mistakes, and gained insight into their problems, teaching becomes a thrilling experience. The challenge is exciting because of the tremendous demands upon the creativity and resourcefulness necessary to meet the needs of the pupils. Teaching becomes a real adventure because there is no certain road to travel nor definite signs of learning. The successful teacher becomes dynamic, sympathetic, understanding and persevering. These are the "fringe benefits" of teaching the retarded.

Guidelines for Special Classes There are very few catechisms or manuals specifically written for the retarded. Some progress has been made by various national groups, i.e., National Association of Retarded Children (or state affiliate), the National Apostolate for Mentally Retarded, American Association on Mental Deficiencies, by making available lists of recommended catechetical texts and visual aids. A letter to them will be answered with a list of materials and various methods already tested and approved. The chaplain may choose any approved catechism or manual and adapt it to meet his needs.

Once the guide is chosen the chaplain should outline the lesson in a simple format. Only one truth should be taught per class. The truth should be presented in several ways, as repetition is the mother of knowledge for the retarded. The ultimate goal is knowledge, so that if the truth must be taught for one, two or three classes the time will not be wasted. The chaplain may become tired of repeating the story, song, or theme over and over again, but the pupils will warmly identify with the characters and will more eagerly enjoy the lessons. Repeated use of activities will allow skill to develop and, with it, added enjoyment. The wise chaplain will establish easily attainable goals at first to give the pupils confidence and encouragement. Once they have tasted success they will strive to reach goals more rapidly.

Time is important because of the brief attention span of the retarded person. The chaplain must develop various ways of keeping their attention. "All work and no play" makes the class dull

and tiresome. The net results are lack of interest, misbehavior, interruptions and loss of pupils for the next class. A sample lesson plan might be organized like this:

5	10	minutes—Greet the class and free play.
10	20	minutes—Group activities, story-telling, film strip and record, cut-outs, all which will be used in the lesson.
5	10	minutes—Lesson and moments of worship in prayer.
5	10	minutes—Finish projects, clean-up, and personal conversations or instruction.
5	10	minutes—Preview of next week (arouse their interest for the next lesson).
30	60	minutes

If more time is available, a snack can be introduced (cookies and milk or kool-aid) and more time for personal attention. Whatever time schedule is used, it must be flexible. The chaplain will become "sensitive" to the mood of the pupils and will not hesitate to take advantage of learning opportunities. One advantage in using the above time schedule is that the pupils and chaplain may "socialize," something they ordinarily do not have.

Creativity and Resourcefulness From the outline above, it is evident that the chaplain must be able to adapt all of his skills to teach the lesson. Story telling, puppet shows, crayons and paste, "make-believe" play-acting are all methods of teaching. Anything that will interest the pupils can be used. How to gain their interest? More than most people, the retarded depend on their senses to gain knowledge; therefore the more senses used at one time, the greater the impression on the pupils. For example, if a film strip and record are used, the eyes and ears are stimulated. If an object is made, the eyes and hands are working together and the ears will be listening for instructions. At times the chaplain may become frustrated as the pupils will remember the example or project and forget the lesson. This indicates a teaching error in the misuse of an activity, overemphasis upon it, or failure to relate the activity to the lesson.

The retarded have great difficulty in understanding abstract principles or ideas. It is difficult for them to grasp the concept of arithmetic for they cannot "visualize" numbers. Teachers use

examples of apples, oranges and pears added together. Everyone laughs at the idea of fruit salad as the correct answer, but the fruit, being tangible, can be combined while the numbers, being intangible, are forgotten. Teaching religion is similar, because intangible concepts must be taught in concrete form. The virtue of charity is difficult to explain, but an example of charity at work is usually understood. The fact of God creating everything is hard to comprehend, but the wise teacher who asks what has been created by God will receive countless answers, all from sensory perceptions.

Specific Goals The chaplain must establish specific goals for the classes. It is unrealistic to expect "custodial" retardates to learn the "Our Father," "Hail Mary" or other prayers. The "trainables" can learn these prayers and the "Do's and Don'ts," as the commandments are sometimes called. The "educables" are able to learn and understand anything that a child of nine or ten can grasp. Each group has its own expectations and therefore should be taught accordingly. It is very important that the chaplain establish a goal for the group. This goal is the reward and must be attainable. Since the classes are aimed at the proper reception of the sacraments, no child should be denied except for grave cause.

Volunteers Volunteers are a necessity in a large institution. It is impossible for the chaplain to conduct all the religious education classes, perform administrative paper work, attend all team or unit meetings, and counsel retardates and parents without some assistance. A call for volunteers from the local CCD director or college or high school principal or an advertisement in the local Catholic paper will usually bring assistance. All volunteers should be screened to make certain that they are qualified to teach religion and are acceptable to the institutional authorities.

Orientation is the key to good volunteers. A complete explanation of mental retardation and what can be expected is the first step. Be honest and forthright, treating the volunteers with respect. Allow them to meet some of the retardates so they can undersand their problems. The orientation program should include the modern methods of teaching and a demonstration of the audio-visual aids available. For the convenience of the volunteers a list of do's and don'ts should be available. Such a list will be found at the conclusion of this chapter.

Experience has taught that an on-going orientation program is essential. This enables the chaplain to communicate freely with the volunteers and they in turn can share experiences, ask questions, and solve problems before they become serious. Try to keep an "open door" policy. If the volunteers are treated properly they will be invaluable emissaries to the retardates and, as an extra bonus, will attract other volunteers.

Counseling The chaplain to the retarded wears many hats as an integral part of the institutional team. Counseling, family relations for social service, refereeing disputes, "father figure" to some, repairman to others, always at the beck and call of the residents; these are just a few assignments he confronts during the ordinary day. In a broad sense, the term "counseling" covers these interpersonal relationships. The chaplain should have academic as well as practical experience in counseling before being assigned to a position as chaplain. If for some reason this was not possible, the chaplain should avail himself of such training. He is seriously handicapped without it.

The retarded have many problems and need assistance in their personal lives. Because of the unique position the chaplain enjoys, the retardate feels free to discuss these problems with him. Simple solutions given in an off-hand manner are not the answer. The problem is real, although perhaps blown out of proportion, and the person should be regarded with kindness, consideration and acceptance. Every effort should be made to safeguard his privacy. If outside help is needed or if another professional must be consulted, then it seems obligatory to obtain the retardate's permission.

Parents and relatives often need counseling. How can one explain why a child is born retarded or handicapped? They may display helplessness, grief or guilt in varying degrees. At this time parents can be reminded that every child is a gift from God and a handicapped child a more precious gift. They must be assured that every child has a place in God's plan, as well as in the family, and that no action of omission or commission on their part is responsible for the condition of the child. Why God has entrusted them with the care of this special gift is not always known or understood.

The chaplain should try to console the parents but also help them to accept the child's handicap. If the handicap is not accepted, parents sometimes travel from doctor to doctor, looking for medical miracles. Unscrupulous doctors promise anything and charge exorbitant fees to provide an impossible cure. The parents' hopes are raised only to end in despair—and perhaps in financial bankruptcy. This may sound too dramatic but it is true. Once parents accept the handicap, the child can take its rightful place in the family. Professional help can be secured and the child will be physically, mentally and emotionally assisted.

Perhaps the most important decision parents may need to make is whether to institutionalize the child or care for him in the family. Every case must be decided on its own individual merits. If the child can be given the necessary medical care, educational training, and emotional stability, along with tender loving acceptance, in the home without causing parents or siblings undue stress, he should remain in the home. Sometimes the child must be institutionalized for its own good and for the emotional health of the family. For these reasons parents may have to place their child in a reputable institution. The parents' sacrifice may be a thousand times more difficult in allowing the child to take advantage of the professional assistance given in most institutions. The chaplain, after giving both sides of the argument, must leave the final decision to the parents.

Conclusion

The chaplain's vocation in this apostolate is clearly one of love. The many difficulties, frustrations, and exhausting demands made upon him can only be borne because of his priestly love for souls. Pope Paul, delivered a message to a meeting of religious educators of the retarded which is particularly relevant to those who bring light and love to these children of God.

"We prefer to give to you a word of encouragement for the most difficult task of yours. It is always difficult to be educators but how much more so when this education has to deal with persons whose intelligence is swallowed up in a rebellious nature. Above all it is necessary to have love. It is this supernatural love which brings about a deep respect for life, for the sacred character of the person and the absolute and mysterious value of his dignity, even for

those beings, deprived, humanly speaking, by nature. No matter who the person is, he is always a human being, created in the image and likeness of his Creator, and called by Christ to participate in the same Divine Life. Such is the deep supernatural vision which guides your efforts. . . . Better than anyone else you know how much abnegation, sweetness and utmost patience it entails. The empirical approach is not enough today. A true psycho-pedagogical formation has become indispensable in this field where so much has been accomplished by the specialists. It is also necessary to possess many qualities of intelligence and heart as well as the conviction that such education is possible, regardless of the lack of apparent results, and a relentless perseverance in order to create an atmosphere favorable to trust and confidence, capable of creating friendliness and to make the work progress. It is your dynamic love for such handicapped creatures that moves you on and which is the only factor that can contribute to the good development of their personality.

"In the same way the Church, which has already done so much on behalf of her less fortunate children, cannot but rejoice in your efforts."

THE RELIGIOUS EDUCATORS GUIDE

1. Establish a definite classroom routine and adhere to it until the pupils adjust to it. After the basic routine has been learned and followed, change can be introduced gradually. The mentally retarded need a routine to follow.

2. It is important to begin each lesson with a review of known material. Always work from what the children know and enjoy to what is difficult. Watch your language—avoid abstractions or generalizations. Avoid using historical and remote cultural materials in detail. These children live "NOW" in the television age where history and fact are presented with great immediacy. Therefore adopt a "You Are There" format.

3. If children are taught in groups, individual assistance may be given to those who need it while the others are working on projects. Do not show favoritism either to the "brighter-lights" or the "snail-pacers" of the class. Give the assistance which each group requires.

4. When teaching the lesson, use short, simple sentences. Speak slowly and deliberately, giving the pupil time to hear and respond. If the pupil does not respond, the teacher should repeat the question or direction in the same manner. If no answer is given, the teacher should give the answer and have the pupil repeat it.

5. Each pupil should be encouraged to participate in some way, even if it is non-verbal. The teacher should guide the pupil to respond by pointing, nodding, by a sound or some sign that has meaning for both pupil and teacher. Haste makes waste in time, energy expended, and teachers' nervous systems.

6. For each lesson to be taught a variety of teaching devices should be used. The teacher should decide which method is best for a particular class and prepare accordingly. Since "one picture is worth a thousand words," a picture file is a must. Current magazines can be used for scrapbooks or flannel graphs. Film strips and play-acting are enjoyed by all. Use the method suited to the class.

7. The purpose of "activities" is to aid learning. It is senseless to use activities to fill time or as recreation in a day nursery program. A teacher must teach at all times.

8. The teacher must never promise anything that cannot be given "here and now." If the teacher cannot fulfill the promise, how can he or she be trusted? How can the pupils believe what he or she is teaching? Obviously, the teacher cannot obligate another.

9. The teacher should not attempt to give counsel or guidance in an area that belongs to another profession. Some children indulge in fantasy talk to gain attention—listen with friendly interest but discriminate between fact and fantasy. The teacher will save himself or herself much embarrassment if she checks out the facts before criticizing or condemning anyone.

10. Smile and the class will be happy and everyone will enjoy learning about God. Give freely of your friendship and you will gain riches superior to earthly treasures.

Chapter Eight

PASTORAL MINISTRY TO THE AGING

Jerry Niklas

In the spring of 1971 the Lawrence Welk show was threatened with cancellation. After the announcement was made, TV stations were deluged with thousands of pleas to allow the Welk show to continue. Most of the correspondence came from the older generation. These thousands of letters are just one indication of the large population of senior citizens living in our country—and of their special needs and desires.

The population is growing older because more people are living longer. Today there are almost 20 million Americans over 65, which means that about 10% of the population belongs to this category. By 1975, it is predicted, there will be more than 22 million elderly. In addition, the elderly population is getting older. Today 4,574 persons receiving social security benefits are 100 or more years old. More than 7 million of the 20 million elderly are 75 or older. By 1980, it is estimated that there will be 9 million persons over 75.[1]

This increase in the aged in our country is supported by statistics which indicate that the life span has increased greatly in the last 50 years. Today, the average life expectancy for women is 75.1 and for men 67.9. This is a drastic change from 1920, when the average life expectancy for men was 54.4 and for women 55.6.[2]

Ideally, these millions of older people should have meaningful lives and be assured of a fulfilling and satisfying old age. Realistically, this is not the case. They suffer many losses. Many are

[1] White House Conference On Aging, U.S. Dept. of Health, Education and Welfare, Washington, D.C., 1971.

[2] 1972 Life Insurance Fact Book, Institute of Life Insurance, New York, New York.

widows or widowers, besides having lost a number of relatives and close friends. Formerly they lived in homes of their own and had a definite voice in how they were run. But as senior citizens many of them live in homes owned by their children or in some type of nursing home, and so lose their status and role. Since many elderly persons are retired, they also experience a drastic loss of income. Finally, they are often hampered by physical handicaps, suffer some impairment in hearing and sight, and have difficulty in remembering recent events.[3]

Much of the accumulated wisdom of the elderly is no longer of value in guiding the young because the world has changed too much. Their status is further diminished by the fact that in our society achievement through work has been the criterion of worth. "As a result the elderly themselves, as well as younger people, equate worklessness with worthlessness." [4] Modern society seems to have no real place for many older people. Consequently, many of them feel aimless and bored and suffer from chronic depressions.

The old adult is psychologically as different from the young as the child is from the grown man. The elderly individual is a unique personality who requires special consideration to fill his many needs.[5] Most of these are personal and spiritual in nature.

NEEDS OF THE ELDERLY: PERSONAL AND SPIRITUAL

The personal needs of the elderly who are long-term patients in nursing homes were identified by the administrative staff and the interfaith chaplains' committee of the A. Holly Patterson Home in Uniondale, New York. In 1970 they observed their patients carefully and discovered 14 personal needs. Although these were identified specifically as personal needs of long-term institutionalized patients, elderly people generally experience most of them. They are:

- Need for affection, friendship, and recognition as individuals.

[3] Schoenberg, Carr, Petetz, Kutscher, *Loss & Grief*, New York, Columbia University Press, 1970, pp. 199–204.

[4] 1971 White House Conference on Aging.

[5] Donahue, Wilma, "Psychologic Aspects in the Management of the Geriatric Patient," in E. V. Cowdry, (ed.), *The Care of the Geriatric Patient*, St. Louis, The C. V. Mosby Company, 1958, p. 27.

- Need for a sense of forgiveness and for assistance in handling various guilts and other negative feelings.
- Need for continuing contact with a significant religious community outside the institution.
- Need for reassurance, understanding, and a sense of belonging.
- Need for a sense of meaning, purpose, and "summing up" of life.
- Need for a hopeful future.
- Need for assistance in making transitions and adjusting to institutional life.
- Need for assistance in coping with physical and mental changes.
- Need for assistance in handling personal crisis situations.
- Need for assistance in handling bereavement and feelings of grief and loss.
- Need for a sense of independence, self-control, and self-direction.
- Need for participation in meaningful group experiences.
- Need to give affection.
- Need for continuing growth, both mental and spiritual.[6]

Many studies have verified that the elderly also have spiritual needs. Dr. Edgar Jackson emphasized this point at the Annual Conference of Pastors, stating in no area in psychiatry is religion more important than in that branch of psychiatry which deals with the problems associated with the process of aging. As people grow older they become more concerned with the problem of finding a meaning for their lives. As they look back over the years, they raise the questions of "why" and "wherefore." They become more concerned with the problem of existence, and death suddenly becomes a reality which has to be considered as an imminent event. As a result, many turn to God and religion and seek forgiveness of their sins.[7]

It is true that church attendance decreases because of the infirmities of extreme old age, but hearing and watching religious programs on radio and television increase as a substitute. Since

[6] Mitchel, Monroe, A.J.H.A., "Chaplains and Long-Term Care," August 16, 1970, Vol. 44, Part 1.

[7] Jackson, Edgar B., "Religion, Psychiatry and The Geriatric Patient," Annual Conference of Pastors, Osawatomie, Kansas, November, 1959.

most older people grew up in an era when spiritual needs were closely identified with organized religion, they usually look to their church and clergyman, not to the physician, the social worker or recreation leader, when they feel a need for religious support.[8]

Unfortunately, older members often are hesitant in seeking aid from the Church because they feel that it does not give them meaningful roles anymore, that it is preoccupied with the younger people and that it ignores their opinions. The Church seems to make little effort to reach out to them, for example, by offering them transportation if they need it to attend Mass. Instead, it excuses them from attendance and thus shuts them further out of participation in the community.

MEETING THE SPIRITUAL NEEDS

In an attempt to satisfy the spiritual needs of elderly Roman Catholics, the chaplain makes available daily or frequently the celebration of the Eucharistic Sacrificial Meal, brings Holy Communion frequently to those who are bedfast, and provides an opportunity periodically of receiving the Sacraments of Penance and the Anointing of the Sick.

In the Eucharistic celebration it is surprising how well most of the elderly adapt to the liturgy. If the chaplain explains the liturgy kindly and thoroughly, and indicates by his actions that he is convinced of its value, they will try their best to adjust. At least most of them will cooperate, and this should not be too surprising since these people were reared in an era when the priest was boss and what he said was law. It must be expected that a few will still recite their rosaries and say their novena prayers during Mass, but most will comply with "Father's" wishes.

The liturgy offers opportunities to fill spiritual as well as personal needs. The offertory procession, for example, is an excellent opportunity for making them feel important and needed. When they take their turn presenting the water and the wine or the ciborium they feel they are contributing something special to the Mass. As a result that day will be significant in their week. Many also enjoy the "sign of peace." This is a beautiful time for them to soothe the arguments that may have arisen among them and also

[8] 1971 White House Conference on Aging.

to receive a personal greeting from the priest, which they always consider a privilege.

The chaplain can take advantage of the emphasis on singing in the liturgy to help create a sense of community among the residents and to impart some "spiritual therapy." This type of therapy is a counterpart to occupational therapy in homes for the aging. In occupational therapy, the senior citizens are encouraged to play cards, checkers, crochet and in general to keep their minds active. In "spiritual therapy" the chaplain brings back memories of the "old church." One way to accomplish this is to set aside one Sunday of the month for singing some of the old religious songs they knew as children. If modern hymns are suitable for the "Now Generation," old hymns are appropriate for the "Then Generation."

The organist of one home who celebrated her 80th birthday a few years ago plays such hymns on the first Sunday of every month. She selects songs like "To Jesus Heart All Burning," "Holy God"—music that recalls the past for the senior citizens. When attempts are made to sing modern songs composed after World War II, many of the elderly sing softly or just stand in silence because they are unsure of themselves. But when a song they learned as a child is sung, such as "O Lord, I Am Not Worthy," they come alive and their voices boom out loud and clear. On the first Sunday of January in 1969, when snow was on the ground, one congregation of old folks heartily sang "On This Day O Beautiful Mother." Even though it was out of season, it was still beautiful.

Another practice of "spiritual therapy" is to invite students from a local parish or high school to come to the home and play guitar music at Mass. This is done in an effort to keep the residents informed of what is happening in the Church today. After one guitar Mass, an elderly man commented: "That Mass wasn't so bad; it wasn't as lively as I expected it to be. Besides, those kids really were serious and prayed during Mass."

Every opportunity ought to be given to those who cannot participate in the Eucharistic celebration to receive Communion frequently—even daily, especially during the Easter season. Those who care for the sick may also receive Communion with them, providing the usual requirements of the Eucharistic fast are fulfilled.[9]

[9] "Rites For The Sick," International Committee on English in the Liturgy, Inc., 1971, Washington, D.C.

Since the bedfast can receive Communion at any hour, an atmosphere of recollection can be created by having a specified time for Communion. Receiving the sacraments need not be a somber experience; rather it should be a joyful celebration. However, the joy should be a joy in the Lord, not in the afternoon ball game, since the sacraments are privileged moments of a personal meeting with Christ.

It is not necessary to stress the fact that if a person cannot distinguish between table bread and the consecrated Host, he should not be permitted to receive Communion. This applies especially to the senile. But since they, too, have lucid moments, the decision as to when they can receive is best made on a day to day basis, keeping in mind "Sacramentum propter homines." [10]

In regard to the Sacrament of Penance, most senior citizens find no difficulty in making an almost public confession in hallways, dining rooms or wherever they happen to be. The anonymity of the darkened confessional, which many Catholics guard so jealously, means nothing to them. If the elderly attempt to go into a regular confessional, many have difficulty in kneeling because of insufficient lighting. Others in wheelchairs almost fall out while leaning forward to hear what "Father" is saying to them. If there are no steps leading to the sacristy, it is easier simply to hear their confessions there or in some room near the chapel. A room like this also reduces the possibility of others overhearing confessional matters.

In the matter of scheduling confessions the senior citizens often prefer the old custom of going the Thursday before the first Friday. They find it most convenient if the chaplain can schedule them immediately before or after some meal. The chaplain will have to make allowances concerning the requirements of sufficient matter for the sacrament. Today, there is great emphasis on giving individual penances that are in some way related to the sins confessed. Most elderly people would be confused by these new penances and find it much easier to pray the usual "Our Fathers" and "Hail Marys."

The Second Vatican Council preferred the name "Anointing of the Sick" to "Extreme Unction" and said that as soon as any one

[10] Sister Maria Jude, O. Carm., "Pastoral Care To The Aging," Minneapolis, Minnesota, National Association of Catholic Chaplains' Convention, June, 1969.

of the faithful begins to be in danger of death from sickness or old age, he should receive the graces of this Sacrament.[11] The crisis of serious illness can come quickly, as in the case of a stroke or heart attack, but usually with the aged there is no marked, sudden change but a gradual, almost imperceptible decline which can be noticed first by the nurses who care for them day after day. The priest who works in close coordination with the medical and nursing staff of any nursing home can request them to report these vital changes to him so that he can anoint the elderly when they are conscious and can participate fully in the graces of the Sacrament. The thought of being anointed frightens some elderly people who still regard this as "last rites." The priest can help prevent unnecessary fear by clearly explaining the purpose of the Sacrament before anointing.

In administering the anointing an effort should be made to capture the spirit of St. James, who indicated in his epistle the interest of the whole community in the welfare of the sick.[12] It is fitting, then, to administer the Sacrament when the family or members of the community are present. The presence of others is a sign that the Christian community stands by the aging with genuine loving concern. It is equally a sign of the continuing love and presence of Christ, faithful in sickness and in health. Through this Sacrament He is present to the elderly person just as truly as He was to the suffering men and women of Galilee and Judea. He asks of the elderly now exactly what He asked of Jairus: "Do not be afraid; only have faith."

Along the streets of Nazareth and Jerusalem some were cured of their illness, others were given courage and patience to find meaning and hope in the shadows of life. So today, the power of Christ brings healing to those who receive this Sacrament with faith—sometimes physical healing or improvement, other times renewed hope and insight into the deeper meaning of suffering. Further, Christ reminds the recipients of the anointing that until those happy days of heaven: "My grace is enough for you, power is at its best in weakness." [13]

If the Sacrament is understood in this way, it becomes a joyful, comforting experience, reminding the aged person that Christ and

[11] Constitution on the Sacred Liturgy, Dec. 4, 1963, No. 73.
[12] James 5:14
[13] II Corinthians 12:9

we Christians still love him and that old age offers privileged moments of Christian growth. Anointing a group of the aged in the chapel at Mass or outside of Mass contributes in creating the desired atmosphere.

Sometimes the aged who have not been to church for a long time seem very hardened in their habit of irreligion. The chaplain maintains interest in these "hopeless cases" because a number of them are eager to return to their Creator when they realize they are dying. Dr. Byron Stinson, an assistant professor of psychiatry at Ohio State University, supports this because he feels that people adopt the values they had as children when they begin to die. Since most people have had some type of religious training, he feels the dying are generally anxious to have assistance in relating to their Maker. In his experience, it does not seem to matter if they have not prayed or gone to church for years; they still usually accept the faith of their youth at this time.[14]

Where there is a chapel connected with the home, the priest can do a great deal to relieve the anxiety of the elderly concerning their death and funeral. The beauty of the liturgy of the Resurrection Mass can have a profoundly comforting effect upon old people. The Paschal candle, the singing of the Alleluia and the white vestments have taken away the morbid and somber attitude toward death and replaced it with Christian hope. The effect upon the aged at the Madonna Residence in Brooklyn, New York, who have assisted at these Resurrection Masses has been an alleviation of the fear commonly associated with death.[15]

Senior citizens frequently recall their past, when they were healthier, independent and useful. They enjoy it immensely when they can participate in some old religious customs of their youth. One such custom is the ceremony of the crowning of the Blessed Virgin Mary. One lady who was selected to crown Mary said to the chaplain after the ceremony: "You know, Father, when I was in grade school the sisters always chose the pretty little girls with the curls. I didn't have any curls, Father, so I had to wait until I was 72 to crown our Heavenly Mother." Not only did this ceremony make this lady very happy, it also alleviated the monotony of the daily living of many others.

[14] Stinson, Byron, M.D., "Recognition and Therapy of Depression," Ohio Medical Education Network, January 12, 1972.

[15] Sister Maria Jude, O. Carm., "Pastoral Care To The Aging."

Another practice of the old Church which is very important to the senior citizen is the celebration of the solemn closing of the Eucharistic Adoration (Forty Hours). Parish priests are engaged in many activities in the Lord's vineyard, and seldom find time to visit the homes for the aged. Yet, when they come for the closing of the Eucharistic Adoration, they usually take advantage of the opportunity to visit their former parishioners who are now residents in the home and enjoy talking about the "good old days" at the parish.

In a nursing home, clergymen of all denominations are welcome to visit residents who are members of their congregations. A room should be available for privacy if needed. In the spirit of ecumenism provisions ought to be made for the residents to participate in the services of their denomination.

In caring for the aged person in his own home, programs should be devised which encourage the widest possible participation of all the parishioners, since it is the concern of all the members of a parish community to care for those in special need. Simple instructions on basic pastoral approaches might be made available to those who engage in visitation so that they will know the most effective ways of speaking the faith to and praying with the aged. It is expected that the priests of a parish will aid in organizing this wide-based participation and give the program the benefit of their experience and leadership. Naturally, such leadership includes continual personal involvement in the visitation program. This ensures their availability, especially to those who are dying.[16]

A shut-in appreciates it deeply when he can receive Holy Communion at home on a regular basis. Some like to receive weekly, others monthly. When the aged person receives Communion, he has an excellent opportunity to seek the graces he needs to bear up in a Christ-like manner under the difficulties he experiences in daily living. A by-product of participating in this Sacrament is that the elderly person realizes he is still part of the worshiping community of his Church and has not been forgotten. If the priest has a number of Communion calls in his parish, lay distributors of Communion could assist him in meeting the needs of the shut-ins.

Many aged people have not been able to participate at Mass in church in years and consider it a privilege to have Mass celebrated

16 Sixth Synod of The Archdiocese of Cincinnati, October 23, 1971, "The Document On Worship," page 84.

in their homes. The priest need not make all the preparations himself because the laity, given some instructions, can prepare for the "home Mass," including setting up the altar.

A final aspect of meeting the religious needs of the aged concerns prayer. Popular belief has it that the elderly can now pray more because they have so much leisure time at their disposal. This is simply not true. The elderly often experience loss of concentration and inability to stay awake. As a result, they are at times plagued by guilt feelings for not praying. The priest can help alleviate such feelings by listening and later giving reassurance that God understands their good intentions and loves them dearly.

MEETING THE PERSONAL NEEDS

Senior citizens often feel that they have been shoved aside. Visitors come very seldom, in their estimation, and they feel that their children and other relatives are no longer interested in them and that they are no longer worthwhile. One means of helping them realize their dignity is to keep them informed about the religious ceremonies and other events taking place in the nursing home. It is also important to inform them about events taking place in the community in which they now live as well as their former community.

There are other means the priest can use to help fill the personal needs of the aged. First, senior citizens appreciate it when the priest visits them in their rooms. It is much easier to visit in the cafeteria, because the priest can see so many in such a short time. However, when the priest makes the effort to go to their rooms and sit down in their rocker or favorite chair, then they can proudly tell everyone at the next meal: "Father came to see me this afternoon and sat in my rocker." At the same time the chaplain puts himself out by visiting in their rooms, he is communicating to them by his action that they are worthwhile. It is important to bear in mind that the chaplain is often the only priest whom most of them ever see. When he calls on them, it is the Church showing an interest in one of its senior members, it is Christ concerned about one of His creatures.

In these visits the elderly appreciate it when the priest inquires about their interests. If he looks carefully around the room, he will

find trinkets that many might consider junk because of their age and appearance. Yet to these people articles of this kind are valuable and have meaning. It might be a picture of their grandchild or of their former home. But no matter what it is, they delight in talking about it.

A second means of indicating their dignity is the effective use of the homily at Mass. On the Feast of Corpus Christi, for example, the celebrant can easily use the occasion to point out that the most important Person in the whole world is concerned about them—so intensely interested that He chose to come to them in Holy Communion. On Good Friday a similar application can be made by reminding them that God loves them so intensely that He wished to die for them. The constant repetition of the idea that they count, that God loves them, that He is interested in them, is beneficial for them both spiritually and psychologically.

In addition, a brief thought at Mass, well expressed, can have great value in calming some of their fears and giving them the courage to continue their struggle. The priest also might use the homily to promote charity, kindness, and hope among the aging, keeping in mind that his own pleasantness and optimism can be a homily in itself.

Soliciting the aid of youth groups, high school and university students, and church societies in visiting the elderly is a third means of filling some personal needs. Many such groups bring gifts to the elderly at Christmas time and sing carols for them, but the sad fact is that the old people are forgotten during the rest of the year. The priest can do a great service by persuading some such group to take a year-round interest in the nursing home as a special project. Often a group will begin such a task with great enthusiasm, but slowly their interest will die because the members have not worked through their own feelings about becoming aged themselves. The priest should urge an expression of feelings in this matter. He can also stimulate interest in this work by discussing with the members the needs of the senior citizens and how they are contributing to meet these needs.[17]

Since the priest often constitutes the strongest link with the past, he makes his fourth contribution by helping the old people

[17] Sprague, David W., M.D., "Care Of The Aged," Masonic Home, Springfield, Ohio, February 21, 1972.

adjust to their new life, away from the comforts of their own homes and familiar surroundings. Usually it takes several weeks before the elderly can become comfortable. During this adjustment period everything imaginable will be wrong with the nursing home —the food, the temperature in their room, the unfriendly manner of the nurses, aides, and the other residents. The priest can ease the adjustment period by listening to the complaints with understanding.

One of the key problems of the aging is the frightening thought that there is no longer any meaning to life. When they become aware of their gradual decrease in physical and mental powers, they begin to fear that they have become useless and unwanted, a burden to others. Many old people express their feelings of lack of purpose and meaning in comments such as: "I am no good for anything any more," or "I am useless and not needed any more."

The priest makes his fifth contribution by helping the elderly find meaning in life. There is no set meaning for all aged people because each man must find his own meaning. Even though the meaning of existence is unique for each individual, it is not invented but discovered. The priest's role is to broaden the person's field of vision and help him become aware of the whole spectrum of meaning and values. The priest begins by searching with the person for meaning in life by drawing from his religious beliefs and then strives to find other meanings from his interests, daily influences, etc.[18]

The elderly must become involved with someone or some project in order to continue to find meaning in life. It is not sufficient for them to be involved emotionally only with their children because then they just sit around waiting for the children to visit and complain when they do not come as frequently as they think they should.[19]

Of all the qualities necessary to minister pastoral care effectively in meeting the spiritual and personal needs of the aged, the most important is understanding. Sister Maria Jude paraphrased the beautiful admonition of St. Paul to the Corinthians on charity in urging priests to strive for this quality.

[18] Deeken, Alfons, *Growing Old, And How To Cope With It* (New York: Paulist Press, 1972) pp. 68–73.

[19] Sprague, David, W., M.D., "Care Of The Aged."

The Understanding Chaplain [20]

"Though I preach with skill of the finest Chaplains
And have not understanding
I am become only a clever speaker and charming entertainer, . . .
The understanding Chaplain is very patient, very kind;
Is not shocked when the old people
Bring him their grievances;
Does not gossip; is not easily discouraged,
Does not behave in ways that are unworthy,
But is at all times a living example to his Aging
Of the good way of life of which he speaks.
Understanding never fails . . ."

Corinthians 13:1, 4-8

[20] Sister Maria Jude, "Pastoral Care To The Aging."

Chapter Nine
PASTORAL MINISTRY OF CHILDREN

Donald W. Delaney, M.D.

The importance of the Christian milieu in the general hospital and health care setting can be demonstrated reasonably and simply in the pediatric sections of the hospital. The admission of a child to the hospital, whether planned or emergent, is a time of stress and crisis within the family. Mother, father, brothers and sisters are on "edge." During such times of stress and crises a child's sensitivities are sharpened; new experiences are more likely to affect him and they can either aid or impede his development. His new experience in the hospital can be a positive force in his development if his caretakers genuinely *care* for him and his parents, love them, recognize in them their Christ-likeness, are honest and open with them, and understand their fears and anxieties. These attributes in all members of the child health team establishes the Christian milieu so that the hospital experience of the child will be not a fearful, traumatic one but rather a positive experience of optimism, love, hope and goodness—a truly religious experience which can enhance the child's spiritual development as well as his general maturation.

In addition to his classical role, the administration of the sacraments of Christ, the priest-chaplain can be vital in directing the establishment of this Christian milieu on the pediatric unit, by monitoring it constantly on his daily rounds, by continuing to support it with his presence and his hopeful attitude, and by participating in continuous in-service education programs of the child health team personnel. To carry out this role with ease, the priest-chaplain should have some knowledge of family dynamics and an understanding of the behavior and reactions of the child and his parents.

A. *The Chaplain and the Nursery*

The priest-chaplain is called to the nursery for the baptism of infants who are in danger of death. About 22 infants of every 1,000 live birth infants die during the first year of life in the United States[1] with the majority of these deaths occurring during the first week of life. Prematurity, congenital malformations, and post-natal asphyxia make up the majority of causes for these infants' deaths.[2] Therefore, the immature and premature infant, the infant with respiratory distress, the infant requiring an exchange transfusion or an operation, the infant with newborn sepsis, and often the infant who has no defined diagnosis but who worries the pediatrician and the nurse should be baptized. Because of the urgency of the moment, a member of the nursing staff may be required to baptize an infant before notifying the Chaplain. For his own peace of mind, the priest-chaplain should instruct all nursery personnel, Catholic and non-Catholic, in the proper manner of baptism and should post written instructions in each nursery area. Quiet and kind counselling of any individual member of the team who may be overzealous in the use of Baptism is more apt to result in a cooperative attitude than an abruptly issued mandate which can result in secretive and questionable baptisms in the nursery unit.

If they are available the mother and the father of the newly-baptized infant should be informed in a kind and sympathetic manner. It is the physician's responsibility to inform the parents of the medical condition of the infant, but sometimes the Chaplain may find that the physician and nurse have been unable to do so by the time he arrives to inform them of the baptism with all of its implications. Therefore, a tactful approach by the Chaplain is necessary to lessen the immediate shock of this reality situation.

Parents, even before the arrival of the infant, set up certain goals and aspirations for their child; the child is expected to achieve these goals even before his potential is known. At the time of the birth of the child, the goals, hopes and aspirations

[1] Twelve countries—Sweden, Netherlands, Finland, Norway, Japan, Denmark, Switzerland, Australia, New Zealand, United Kingdom, Eastern Germany, and France—have lower infant mortality rates than the United States. (1970 White House Conference on Children. *Profiles of Children*, 1970. U.S. Government Printing Office.)

[2] *Ibid.*

become stronger and more real. Parents, forced to so soon alter these hopes—as happens if their infant's life is threatened—react with grief, frustration and guilt. Their questions should be answered honestly with the constant assurance that they, the parents, could not have prevented this disorder and that it is not the result of their inadequacies and shortcomings.

If the child overcomes the life-threatening situation and is restored to normal health, then, the health care team, including the Chaplain, has the responsibility to assure the parents repeatedly that their child can live up to their previous hopes and aspirations, instead of the new altered ones. If parents retain any doubt about the health of their child—that he is not perfect in body and mind, that he may be more vulnerable than normal—they will nurture him with a nagging feeling that he should be sheltered, careful in his human relationship and more cautious in the exploration of his environment. While protective they may also be less firm in their control of him. Thus, over the years, an unconscious message is communicated to the child that he is not quite perfect in mind and body. This is similar to the family feud of old wherein the cause of the rift is soon forgotten but the feelings of anger persist and are passed on for generations. So too, the cause of the child's disorder and of the parents' altered expectations are soon forgotten, but the feelings of inadequacy and vulnerability are passed on to the child and may persist for his lifetime.

However, some children are born defective, such as the child with Down's syndrome. This is a terrible shock to the parents and the Chaplain will be called to console them. Not only their aspirations for this child have been shattered but also their own image of themselves as parents has been damaged. The parents need time and counselling to regain their self-esteem and to readjust their hopes and plans. They need to be given permission to approach their child with all of their fears, guilt and modifications, take him home, learn to love him and nurture him, accepting him for what he is, realizing his defects and his potential as time goes on. By loving him, they are loved in return; by accepting him, they have grown in character; by coping with his defects, they have gained a greater self esteem than they would have realized previously. Later, if the child becomes a disruptive force within

the family, plans can be made for him to be cared for outside the home.

B. *The Chaplain and the Pediatric Ward*

The child may be admitted to the hospital on an elective basis for a diagnostic workup or for surgical correction of a physical defect. Proper preparation of the child and his parents is important in reducing his anxiety and that of his family. The parents should be informed and their questions answered to enable them to talk freely about this anticipated experience with the child, reassuring him in a knowledgeable, relaxed manner. When time, facilities, and personnel permit, a pre-admission tour for the child and his parents will alleviate many of the child's fears. Sensitive, perceptive volunteer workers, properly trained, can undertake this task. Special effort should be made to explain to the child what is to be done and why it is being done. Constant reassurance that his body will be the same or better than before is necessary to prevent the child from developing an unconscious image of his body as being altered and imperfect.

More frequently, a child is admitted to the hospital because of some acute illness threatening his vital processes or requiring more sophisticated care than can be provided at home. Circumstances prohibit preparation for either the child or his parents, and it is most important that the Christian milieu be evident to them immediately.

The child is not only ill, but afraid of the unknown—he fears the effects of the illness of his body; the thought of needles, procedures, doctors and nurses who are strangers to him; and most of all he fears the separation from his parents and the familiar surroundings of home. In addition, he is witness to the fact that his illness has upset his parents, the strongest people in his world, and thus his fears are reinforced and magnified. For this reason, he will regress emotionally to a stage of development which will seem infantile, narcissistic and, often, manipulative.

Therefore, it is important that the sick child be treated with kindness, understanding, and concern. He should be shown his new environment, informed of what is expected of him and reassured that his mother can stay with him, if appropriate, or that his parents will be visiting him frequently if circumstances

prohibit his mother from staying in the hospital. During his hospitalization, it is necessary to be honest and forthright with him, informing him, in words appropriate to his stage of intellectual development, of painful procedures at the time when they are carried out. His relationships with personnel should be positive and pleasant ones. If the members of the child health team are punitive or indifferent to him, the child will become confused and, after reflecting on his own actions, he will become depressed. His thoughts may carry him through a series of moods. "I wonder what I did to make them indifferent to me, or (carried to its extreme as children are prone to do) angry with me?" The more sophisticated, older child will interpret these signs as meaning "my illness must be very serious and hopeless if these people, who work with sick children everyday, do not want to become involved with me."

The proper involvement of the hospitalized child's parents is the most important factor in the child's experience, becoming a positive, dynamic force in his development. Parents' attitudes and actions influence the orientation around which a child receives, integrates and interprets all of the new stimuli in this environment. When the child is admitted to the hospital the parents are unsure of themselves in this strange environment; fearful for the future of their child; apprehensive of the pain which he may experience; worried about the dedication and faithfulness to duty of the personnel to whom they are entrusting his care, and concerned that they will be shut out from his care at a time when they want and need to help him. Again, underlying all of these feelings, their most nagging worry is based upon their own feelings of imperfection as parents. Their questions reveal a need to be reassured that the child's hospitalization did not result from something they did or did not do. Parents react to their anxieties in many different ways: depression, irritating questioning, ill manners, bizarre, aggressive behavior. Anger directed toward the personnel may be a reflection of their feelings of their own inadequacy or their feelings of having to compete with the health care team for the affection of their child. Irritation on the part of the staff aggravates the situation and supports their unfounded fears. An understanding and direct approach by the personnel demonstrates to the parents that their fears are unfounded and that their feelings can be discussed freely; usually this will result in a disappearance of the angry, aggressive behavior.

C. *The Chaplain and Death of a Child*

A Chaplain's presence is needed most on a pediatric ward when it is established that a child has a fatal dirorder.[3] Not only the child and his parents but also the personnel on a pediatric ward will appeal to the Chaplain for moral support.

Parents will seek out the Chaplain for permission for their child to receive the Sacraments of Christ. On the other hand, it is our experience that some parents do not know that their seriously ill child, not yet of an age to have made his first Holy Communion, may do so at this time, provided the child has some realization that Christ is being received. In addition, most Catholic parents and many hospital personnel do not know that the priest-chaplain has the faculty to administer the Sacrament of Confirmation to their child, in danger of death. It is a great consolation to the parents and also to the health team members when this takes place.

Parents require a great deal of understanding and consoling. They should be allowed to verbalize their feelings of guilt ("If I had only brought him to a doctor sooner"; "God is punishing me") and grief. The young chaplain quickly learns that parents need a sensitive, sympathetic listener at this time in order for them to ventilate their anguish. Even deeply religious parents may express anger toward their creator and wonder why he has turned on them in this fashion. The Chaplain must understand that this is only a coping mechanism and should neither judge nor revert to religious cliches. We have found that parents of dying children may display the same coping mechanisms that Dr. Elizabeth Kübler-Ross[4] discovered in dying, adult patients, namely (1) denial and isolation, (2) anger, (3) bargaining, (4) depression and, (5) acceptance.

The question always arises "should the child be told?" It is not until the child reaches school age that he begins to view death as

[3] The five leading causes of death in children from 1-14 years of age are accidents, cancer, congenital malformations, influenza and pneumonia, meningitis. (U.S. Department of Health, Education and Welfare, Health Services and Mental Health Administration, National Center for Health Statistics.)

[4] The priest-chaplain will find Dr. Kübler-Ross's book, "On Death and Dying," The Macmillan Company, New York, N.Y., 1969, a very helpful resource. ($1.95 in paperback.)

permanent, and it is often not until about puberty that the child conceives of death as a permanent separation to which he is vulnerable. The pre-school child sees death as temporary ("Grandfather died last week, but we will still visit him next summer") and, as separation from his parents—as if they are out of town. The child may view death as something violent, something about which he should be fearful. Therefore, the younger child should not be told anything beyond his comprehension—he would only become confused and, then, afraid of his confusion. He should be continually assured that he is accepted and cared for. This care should be carried out in a loving atmosphere, demonstrating that his fears of violence are unfounded.

While he is still able to take part in the ward activities, he will know that he is accepted and cared for if he is not allowed to manipulate others and if he is encouraged to take part in activities with other children. As his condition worsens, he will not have the energy to take part any longer, but will still need reassurance that he is accepted. He should be visited by his friends on the health care team, including the Chaplain.

The older child may guess from the reactions of his contacts that something is amiss—hospital personnel including his physician and his parents begin to treat him differently than before his diagnosis was verified. A sensitive, short book, *The Story of Gabrielle* by Catherine Gabrielson (Cleveland, New York, World Publishing Company, 1956) will give the Chaplain insight into this situation. First the parents must be helped to work through their anguish and to accept this child's prognosis. Then, with their knowledge and involvement, the child can be told—provided that the hospital has a sensitive, knowledgeable team to help the child work through to an acceptance of his condition. In individual situations, a child may ask the Chaplain, "Am I going to die?" The Chaplain may respond by asking, "What does death mean to you?" before answering the question. This is not meant to be a hedge, but rather an exploration of the child's concept of death, so that any misconceptions can be cleared up immediately. If the Chaplain so informs a child of impending death, he must share that information with those who are giving the child support and care.

The death of a child is a painful experience to all members of the health care team. They may feel that any display of their

feelings, including talking about them, is a sign of weakness. The Chaplain should initiate a discussion about their feelings of grief and their sense of failure in not bringing this child back to good health.

D. *The Chaplain and the Battered Child*

The maltreatment of children in the United States is a disease with a wide spectrum which includes the physically abused child, the neglected child, and the emotionally deprived child. The true incidence of the disease is not known and the reported cases represent only "the tip of the iceberg" of the problem in most communities and jurisdictions. Children who have suffered non-accidental injuries with resulting bruises, abrasions, burns, fractures, internal injuries including subdural hematomas in infants, children who are malnourished because of nutritional and emotional deprivation, and children who have been sexually molested make up a large number of the visits to a pediatric emergency room or clinic.

The responsibility for the reporting of a child abuse incident to the proper authorities in any given jurisdiction falls upon the medical team members who must be knowledgeable and sensitive to this disorder. An evasive story from frightened parents who tend to blame the injured or neglected child rather than comfort him in the emergency room setting is an early signal which leads one to suspect child abuse. Further diagnostic investigation, including total body X-rays and social services consultation, may strengthen the suspicion. Mandatory reporting of a suspected abused child is required in all states and the District of Columbia so that a thorough investigation can take place. Appropriate treatment can be instituted with the aim of providing an environment for the child enabling him to live, grow and mature into a reasonable and loving adult. This is a tall order and one which most communities have failed to realize. Although the reporting and investigation of child abuse situations is fairly well established, few communities provide adequate treatment modalities for these unfortunate families. To return a physically abused child to his family environment with no rehabilitative measures established for his parents or caretakers is to assure a 20% chance of that same child being killed and a 50% chance of permanent disability, if he should survive.[5]

[5] See reference #3 in bibliography.

It has been shown that parents who abuse their children belong to all social strata and walks of life. However, only about 10% of a studied group can be labeled as psychotic or overtly psychopathic. The remainder are lonely, isolated, fearful persons who were deprived of adequate parenting and love as children themselves and who were the victims of their parents' physical aggressions. The expectations that these parents have of their children is to fulfill the need for that love, that "mothering" which they missed and for which they constantly long. This is too great a task for an infant and given the right circumstances of a passive mate, a family crisis, and a crying baby, a parent may lash out in violent, uncontrolled anger and frustration, hurting his or her child. The parent, ridden with a sense of guilt and failure, will seek medical attention, but will "protect the truth" of the situation.

Starting with his early childhood, this abusing person has learned that his parents were not to be trusted but to be feared and avoided; this same feeling is transferred to all people, especially to those persons occupying positions of authority—the doctor, the chaplain, the nurse. To chastise this battering parent is to strengthen his belief that all authoritative persons are like his own parents and to verify his own impression of being a lonely "loser."

The initial feeling which one may feel when confronted with an abused child is anger toward his mother or his father. This is where the Chaplain can help—by understanding these parents and counselling them in a non-judgmental manner and by communicating this understanding to the members of the medical care team with a spirit of hopefulness for rehabilitation of the family.

Treatment modalities which are proving successful incorporate the tasks of breaking down the isolation of the parents and improving their self esteem. In addition to the traditional psychiatric, protective and social services, lay therapists, crises nurseries, parent self-help groups, day care centers and homemakers services have been successful in Denver, Colorado, in returning about 90% of all children to their families without further incident in those situations which warranted removal of the child initially.[6]

[6] *Ibid.*

The book, *Helping the Battered Child and His Family* edited by C. Henry Kempe, M.D. and Ray E. Helfer, M.D., J. B. Lippincott Company, Philadelphia and Toronto, 1972, is a "must" for every Chaplain's library (available in paperback).

(Note: My appreciation is extended to my Pastor, Monsignor Thomas Duffy, St. Raphael's Church, Rockville, Maryland, for his advice in writing this chapter.)

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Chapter Ten

ADDICTION, HABITUATION, PASTORAL CARE

Walter J. Smith, Ph.D.

Gould's Medical Dictionary [1] defines addiction as "habitual use of some drug, liquor, etc." *Dorland's Illustrated Medical Dictionary* [2] agrees: "the state of being given to some habit." But others see addiction as more than this. Taber's *Cyclopedic Medical Dictionary* [3] defines it as "enslavement to some habit, esp. the drug habit. A condition in which cessation of narcotic or other drug produces definite 'symptoms of abstinence'." According to English and English [4] it is "slavery to a pernicious habit, esp. the taking of certain drugs."

Thus there are two notions of addiction. One would call any firmly entrenched habit an addiction, so that a woman might justifiably say of her husband that he is addicted to golf. The other would require more than habit and demand "enslavement," the notion that the individual is caught and unable to do anything himself to change his condition.

In its strictest meaning, then, addiction implies such a deep-seated urgency that the person cannot control it and must satisfy it regardless of the consequences. The classification of personality disturbances of the American Psychiatric Association lists addiction as a sub-category of sociopathic personality disturbance. While many addicts are sociopathic, many others are not and be-

[1] *Gould's Medical Dictionary.* (5th ed.). Philadelphia: Blakiston, 1941.
[2] *Dorland's Illustrated Medical Dictionary.* (24th ed.). Philadelphia: Sunders, 1965.
[3] Taber, C. W. *Taber's Cyclopedic Medical Dictionary.* (9th ed.). Philadelphia: Davis, 1963.
[4] English, Horace B., and English, Ava C. *A Comprehensive Dictionary of Psychological and Psychoanalytic Terms.* N.Y.: Longmans, 1958.

come addicts as a symptomatic reaction to neurotic anxiety or compulsivity or even to psychotic tendencies. It seems best, therefore, to regard addiction as a symptom manifestation in its own right. The two principal addictions with which the chaplain may come in contact are alcoholism and drug addiction.

ALCOHOLISM

Scope of the Problem

Problems arising from the excessive use of alcohol are probably almost as old as man himself. Until recent years, however, those who characteristically used alcohol to excess were regarded as simply sinful. With good will and concentrated personal effort, it was felt, they would be able to conquer this evil tendency. As a consequence they were punished for their misdeeds and exhorted to do better, and in some instances given a "pledge" never to touch alcohol again.

While most adults in the United States are able to use alcohol in moderation, and do so, it is estimated that over 5 million Americans are alcoholics.[5] For them the excessive use of alcohol is a serious problem.

Definitions of alcoholism stress either the effects of excessive drinking, or the causes, or both. *Gould's Medical Dictionary* emphasizes the effects: "the morbid results of excessive or prolonged use of alcoholic liquors." *Taber's Cyclopedic Medical Dictionary* alludes to both: "Diseased condition due to acute or chronic excessive indulgence in alcoholic liquors . . . psychological factors play an important part, a deep-seated neurosis. Subconscious feelings of insecurity and inadequacy, conflicts and frustrations are factors. Vitamin deficiency." English and English highlight the causal factors although they recognize the effects, too: "A personality disturbance whose most prominent symptom is chronic compulsive drinking. A pathological condition of body or mind, resulting chiefly from excessive chronic drinking."

General Effects of Alcoholism Intoxication

Alcohol is a narcotic; i.e., it does not stimulate, as so many falsely believe, but actually retards a person's activities by slowing

[5] Bier, William C., S.J., (ed.). *Problems in Addiction.* N.Y.: Fordham U. Press, 1962, p. 17.

down the reactions of the higher centers of the brain and lessening their inhibiting effects. As these higher human control centers become less active, lower, more primitive, uninhibited emotions are manifested and the individual starts to follow impulses which he ordinarily holds in check. Motor coordination begins to suffer; his movements become inaccurate and his speech slurred. His sensory discrimination is diminished; he is less sensitive to pain, cold or other discomforts. Unpleasant realities fade away and he feels in a gay and expansive mood in which his worries are temporarily forgotten. Emotionality is increased, while sensory, intellectual, and motor functions are impaired. As more alcohol is consumed, the individual gradually loses consciousness altogether.

Exactly what alcohol does to the brain is not fully understood. It is known to slow down brain functioning temporarily by numbing first the higher centers controlling intellectual functioning, then those mediating sensory-motor behavior, and finally the areas in charge of basic vegetative functioning. It is no longer thought to have the detrimental effects on various bodily organs which were once ascribed to it. Cirrhosis of the liver, polyneuritis and the various psychotic reactions are now considered to be due to the malnutrition which results when alcohol becomes the major source of food values and other items are excluded from the diet. Serious vitamin and mineral deficiencies result and resistance to disease is weakened.

Psychotic Reactions to Alcohol

These are described briefly in order to familiarize the chaplain with their symptoms. He may meet them not only in the hospital, but even occasionally in the parish office or on house calls, and should be able to recognize that the victim is not simply intoxicated, but needs medical attention. He can then advise the family accordingly, or see to it himself. Some indications are also given of the treatment, prognosis, and seriousness of the disorder—valuable information for the chaplain in dealing with the victim himself and with his family.

1—*Pathological Intoxication*

Pathological intoxication occurs in persons who, for one reason or other, have a very low tolerance of alcohol, either temporary or

permanent. Even a moderate amount of alcohol may cause these individuals to become disoriented, experience hallucinations, or even develop a homicidal rage. Sometimes they commit or attempt murder, burglary, arson, or sexual assault while in this confused state. The disorientation and confusion is followed by a deep sleep from which they awake with no memory at all of what occurred.

2—*Delirium Tremens*

The "D.T.'s" are usually preceded by restlessness, insomnia, and general feelings of uneasiness and apprehension. The delirium itself includes:

1. disorientation for time and place; he does not know where he is, may not recognize his family and friends, and may mistake other people around him for old acquaintances;
2. vivid hallucinations, especially of small, rapidly moving animals, like snakes, rats or bugs;
3. intense fear, particularly as these animals change shape, color, and size and threaten and terrify the patient; this may lead to efforts to fight them off, to cowering in a corner, or even to attempted suicide;
4. extreme suggestibility, so that he may see almost anything whose presence is suggested to him;
5. coarse tremors of the arms and legs, and sometimes of the tongue and lips;
6. other physiological symptoms such as excessive perspiration, rapid pulse, loss of appetite, nausea, fever, coated tongue, and foul breath.

Most patients recover in a few days to a week, especially if their nutritional deficiencies are remedied by a high protein, vitamin and mineral diet. Upon recovery, they are usually somewhat remorseful and so thoroughly scared that they may not drink again for a few weeks or even months. Usually, however, the excessive drinking is resumed, unless psychiatric treatment is begun and continued.

3—*Acute Alcoholic Hallucinosis*

Whereas in Delirium Tremens the hallucinations are mostly visual, in Acute Hallucinosis they are chiefly auditory. At first the victim will hear one voice making simple statements. After a time,

however, the voices of several persons are heard, all reproaching him, discussing his private, especially sexual, faults, and suggesting horrible punishments. In addition he may hear clanking chains, gun shots, sharpening knives, or the approach of threatening footsteps. As a result he may scream for help or attempt suicide. This may last for several days or weeks. At the same time, he feels depressed but is coherent and well-oriented except for his hallucinations. With recovery he usually is quite remorseful.

4—*Korsakoff's Syndrome*

The outstanding symptom here is a memory loss, particularly for recent events, which is filled in by falsification. Hence, while these patients may be disoriented, delirious and hallucinated, the confusion and disorder in their conduct are mostly due to their efforts to fill in the memory gaps. When the disorder occurs, it is usually found in older alcoholics after many years of excessive drinking. There may also be polyneuritis, tingling of the extremities, loss of sensation, muscular atrophy, or paralysis.

The symptoms are due chiefly to vitamin B deficiency; a vitamin rich diet ordinarily arrests the condition, but some personality impairment usually remains: memory failure, lowering of intellectual capacity and of moral and social standards.

5—*Wernick's Syndrome*

The main symptoms are lack of coordination and inability to maintain balance in standing or walking, clouding of consciousness, and paralysis of the eye muscles. These result from degeneration of the portions of the central nervous system which mediate these activities. It may occur also in nonalcoholics, as a result of severe vitamin deficiency.

6—*Chronic Alcoholic Deterioration*

Even if an alcoholic never develops any of the psychotic reactions, nevertheless the continued absorption of excessive quantities of alcohol frequently leads to a general personality deterioration. Memory, judgment, and the ability to concentrate may be impaired. Behavior becomes impulsive, coarse, and increasingly irresponsible. The person begins to get careless about his personal appearance, neglects his family, and will stand no interfer-

ence with his drinking habits. They have gotten beyond his control, so he now excuses his behavior by means of obvious rationalizations. His inhibitions at this point have usually been considerably lessened and he may engage in deviant sexual behavior which will further outrage and antagonize his family.

Dynamics

As is apparent from the foregoing definitions, alcoholism is no longer regarded as merely a moral failure. John C. Ford, S.J.,[6] has written: "Personally, I don't think that many alcoholics are formally and subjectively guilty of the mortal sin of becoming an alcoholic. Nobody says to himself: 'Well, this kind of drinking is going to make an alcoholic out of me, but I don't care; I'm going to go right on drinking the same way.' When people warn the potential alcoholic or the dangerous drinker that he is becoming an alcoholic, if he believes them at all, he says: 'Why, I've got to do something about that. From now on, I'll stick to beer.' But he doesn't give up drinking, which, at this point, is probably the only thing that will keep him from becoming an alcoholic. . . . So I do not think that people are often seriously guilty of the sin of becoming an alcoholic. They just don't believe it will happen, or else they do 'something' about it and think that something is sufficient when it is not."

With regard to how much responsibility should be assigned for excessive drinking after the person has become an alcoholic, Ford has written: "I believe that everybody is agreed that in the case of the alcoholic there is a definitely diminished responsibility."

As to the alcoholic's obligation to do something about his drinking after he is able to admit he is an alcoholic, Ford has written: "I would like to insist, though, that those who say that alcoholism is a sickness (and that is the vast majority of all the experts in the field) are not trying to say that the alcoholic has no responsibility for what he is doing or what he is going to do about his problem. The treatment that is suggested by all schools of thought always involves an appeal to the responsibility of the alcoholic. If you didn't appeal to that, you would have nothing to appeal to. And very often when people say carelessly that alcoholism is not a moral problem, or that you can't handle it morally, what they mean

[6] *op. cit.*, p. 42–43.

is: 'Please don't be *moralistic* when dealing with the alcoholic.' Moralistic is an exaggeration of the moral point of view, just as legalistic is an exaggeration of the legal or juridical point of view. . . . I really do believe that alcoholism is a triple sickness of body, mind, and soul, and that all of these elements have to be taken into consideration."

It is generally agreed that alcoholism is not due to any hereditary or genetic predisposition to the condition itself, although there is evidence pointing to a congenital nutritional peculiarity common to alcoholics. Alcohol itself is not regarded as the direct cause of the problem, but its excessive use is rather the symptom of underlying personality difficulties. In any case, the alcoholic is no longer able to control his drinking. Alcohol has become his master.

Excessive drinkers have been found to fall into two classes.

1. *Symptomatic drinkers.* They drink excessively to relieve serious tension and anxiety but retain sufficient control over their intake and manage to carry on their work.

2. *Chronic alcoholics.* These are alcohol addicts who lose control over their drinking, usually after a long period of excessive consumption.

In both these groups the excessive use of alcohol is a symptom of personality maladjustment.

Symptomatic Drinkers

They use alcohol to reduce tension and anxiety. Many are able to keep within the acceptable social norms most of the time, but in times of serious upset may consume large amounts.

Under conditions of extreme stress, even relatively stable individuals may drink too much. This is really *situational drinking*, since it decreases to normal once the stress is past. However, among these individuals are found many neurotic, sociopathic, immature, and otherwise maladjusted persons who tend to progress from situational drinking to continual excessive use of alcohol as a relief measure. Most manage to maintain sufficient control to take care of their daily work, so that technically they cannot be classed as alcoholics. But they are psychologically maladjusted and use alcohol to help ease them through the stresses and strains

of life. Otherwise they would probably develop some different abnormal reaction pattern such as a neurosis or a psychosis. Some portion of this group eventually also lose control and become chronic alcoholics.

Chronic Alcoholics

It is thought that physiological and psychological susceptibility may be responsible for the development of chronic alcoholism. In all alcoholics there can be observed a weakening of control in the "higher" or more strictly human portion of the personality and corresponding release of impulses from the more primitive areas. A pathological need for alcohol becomes more evident as the controlling agencies continue to weaken and finally collapse. There are, however, a few alcoholics who seem to have a pathological desire for alcohol almost from the beginning of their drinking.

Since alcohol does mitigate the effects of unpleasant realities and is so widely available, and its use is socially acceptable, it is not surprising that it is widely used for reducing tension. As a person begins to rely on it more and more for tension reduction, other more direct means of handling tension are discarded, and alcohol assumes the dominant role in adjustment to life's problems. The person may then be said to have become psychologically dependent upon alcohol, and during some time of more severe strain may pass over from excessive symptomatic drinking to chronic alcoholism.

E. M. Jellinek (of the Yale Center for Alcoholic Studies) has broken down the development of alcoholism into four characteristic phases.[7]

1. *The pre-alcoholic symptomatic phase.*

The pre-alcoholic begins drinking in the accepted fashion at social gatherings but soon finds reward in alcoholic reduction of tension. At first he uses alcohol for this purpose only occasionally, but gradually his ability to stand tension decreases to the extent that he uses alcohol for this purpose almost daily. This transition may take several months, or even as long as a couple of years.

[7] Jellinek, E. M. *World Health Organization Technical Report Series.* Switzerland: World Health Organization, Geneva, Aug. 1952, pp. 26–39.

2. *The prodromal phase.*

This is characterized by the sudden appearance of blackouts during which he may show no sign of intoxication, carry on reasonable conversations and engage in complicated activities, but with no memory at all the next day. This amnesia without loss of consciousness, and even without consumption of great amounts of alcohol, is considered to indicate lesser tolerance of alcohol in the prospective addict.

Other related kinds of behavior now begin to appear.

a) *Surreptitious drinking.* Opportunities are sought for having a few drinks without others knowing lest they misjudge if they notice he is drinking more than they.

b) *Preoccupation with alcohol.* This is usually manifested by a great concern as to whether there will be enough to drink at social affairs to which he is going, and maybe having several beforehand in case there is a shortage.

c) *Avid drinking.* He gulps down the first couple of drinks.

d) *Guilt feelings about drinking.* He begins to realize it is getting out of bounds.

e) *Avoidance of talk about alcohol.* He begins to feel uncomfortable about references to alcohol in conversation.

During this time his drinking is heavy but may be relatively hidden from others. He may have some insight into his conduct and may fear its consequences, but he has not as yet developed strong rationalizations about his drinking. If he can be influenced to seek help at this stage, incipient alcoholism may be stopped from further progress.

3. *The crucial phase.*

This is where he really loses control over drink. The first one seems to start a chain reaction, and the drinking continues until he is either too intoxicated or too sick to take any more. He can still, however, control whether or not he will take the first drink; e.g., following recovery from severe intoxication he can manage to stay "on the wagon" for some time, trying to regain his will power. When tensions increase and he seeks his usual antidote he resolves that this time he will take only one or two; but the first drink starts the chain reaction and the same results follow.

Along with loss of control, there is the development of rationalizations for his drinking, whereby he convinces himself that he did not lose control and had good reason for getting drunk. The reasons are primarily to satisfy himself, but they are also used to counteract pressure from others, especially his family, his employer, and his friends.

In spite of rationalizations, however, his self-esteem is greatly lowered. Sometimes he compensates for this by grandiose behavior, a superior attitude, and extravagant spending. This usually gets him into further difficulty, and his remorse, together with the social pressure upon him, increases his tension and drives him more frequently to drink. Then he may resort to rules about not drinking before a certain hour in the day or only in certain places, etc.

About this time he usually begins drinking in the afternoon and is intoxicated all evening. This may cost him some time from work the next day, but he struggles to hang on at least to his job, even though he gradually withdraws from all social contacts.

He is now under great stress and quite hostile to all the world. He drops friends and quits jobs, usually as an anticipatory defense, before he himself is dropped. His increased isolation further aggravates his problem. Now he resents things which interfere with his drinking rather than the opposite. Outside interests are lost, self-pity develops, and he isolates himself from others.

Family behavior patterns also have now radically changed. His family no longer wish to attend social functions with him because of embarrassment, so they turn to activities which will take them away from home. This only increases his resentment and thus adds to his problem.

Stockpiling now has begun. Large supplies are laid in and stored in most unlikely places. Neglect of proper diet takes its toll, and the first hospitalization for some alcoholic complaint may occur. Improper nutrition and related factors have decreased his sexual drive; this increases his hostility toward his wife and he develops "alcoholic jealousy," attributing this to the wife's alleged extramarital affairs.

Now he is so disorganized that he is unable to start the day without a drink to help pull himself together. This leads directly to the last or chronic phase.

4. *The chronic phase.*

His resistance to the domination of his life by alcohol has now so broken down that he becomes intoxicated during the day on weekdays and continues this way for several days until entirely incapacitated. Such drawn-out episodes of drinking are usually associated with marked deterioration of thinking and of ethical standards. These are regained, however, following the spree.

True alcoholic psychosis may occur during this phase, in about 10 per cent or less of alcoholics. By this time his self-esteem has been so lowered that he drinks with persons far below his socio-economic level in preference to his former associates, and he will drink anything alcoholic if his normal sources are not available.

His tolerance of alcohol begins to be lessened. Only half the usual amount becomes sufficient to induce alcoholic stupor; but his system can no longer function comfortably without it. Indefinite anxieties, tension, and even tremors persistently appear as soon as alcohol is removed. He has to control these symptoms by continuous drinking. So he will do anything to get it. While in the beginning alcohol was effective for relieving the tensions resulting from frustrations and conflicts, at this point the drinking is itself causing personality stresses which he attempts to relieve by further drinking.

Finally his rationalizations fail him as they fail to meet continual testing by reality. In about 60 percent of alcoholics vague religious tendencies now begin to appear. Although he continues obsessive drinking, he admits defeat, realizes he does not know how to help himself, and may become accessible to treatment, if he is not too thoroughly discouraged.

Treatment

Habitual drinking is very difficult to overcome. When sober, the excessive drinker makes firm resolves to stop drinking; but as soon as tensions mount, their dissolution in alcohol becomes too tempting for him to resist.

The conviction that his drinking has gone beyond his control takes a long time to develop. When it does, he may give up altogether, and commit suicide or exist on skid row; or, on the contrary, he may turn to outside help.

1. *Ineffective approaches to treatment.*

Making the excessive drinker deeply ashamed and remorseful does not help him to stop. The more humiliated and worthless he is made to feel, the greater is the likelihood that he will turn to his customary escape from unpleasant reality.

Punishment, convulsive therapy, psychosurgery, exhortation, and persuasion have all proved relatively ineffective.

2. *Modern methods of treatment.*

These are based on the realization that drinking is the result rather than the cause of its victim's difficulties. Emergency medical measures are used to deal directly with the effects of excessive alcoholic intake on the organism. The so-called "tranquilizing drugs" are used to control motor excitement and reduce mental anxiety. Vitamin-rich diets are prescribed to improve the physical condition, and organic pathologies are directly treated.

But for long-term results, a program of psychotherapy is necessary to strengthen the individual's personality to the extent that he will no longer find it necessary to escape life's problems by means of alcohol, but will become capable of meeting and dealing with them in a mature and responsible manner. This is usually done most effectively in an institution, where the person is removed from his disturbing environment until such time as he is capable of dealing with it. This is one reason why merely outpatient psychotherapy so often fails.

Conditioned-reflex therapy is useful to interrupt the alcohol cycle for at least a brief period while intensive psychotherapy is undertaken. Psychotherapy is relatively useless until alcohol intake is completely shut off. This method has been reported as resulting in cures in 50 to 70 per cent of cases, but only if the conditioning process is repeated from time to time.

Alcoholics Anonymous, essentially a form of group psychotherapy, involves social activities as well as discussions of the problems of the alcoholic, with religious faith an important factor in many instances. It includes mutual support and reassurance through participation in the activities of others like himself which serve to strengthen him along the way. Reports indicate that about 50 per cent who join recover almost immediately; an additional 25

per cent recover after a relapse or two. But it works only with those who have admitted defeat and seriously want to be cured.

The Role of the Chaplain

Clinebell [8] sees the role of the clergyman in the treatment of alcoholism as six-fold:

a) helping bring hidden alcoholics out of hiding to help;

b) creating openness to help;

c) providing pastoral care and counseling, with particular reference to the spiritual dimension of alcoholism;

d) helping the spouse and children before and during the recovery process;

e) stimulating and supporting the development of community resources;

f) leading his congregation in developing creative approaches to both prevention and cure.

The hospital chaplain may not be able to help in all of these ways to an equal extent, any more than the parish clergyman can. But he can find himself involved in all of them to some extent, even the last, if he considers the whole hospital community his congregation.

With the alcoholic himself, one of the chaplain's main tasks is to bring the person to the realization that the problem has gone beyond his control and that he needs professional help in solving it. This is usually not easy to do. Most alcoholics are unwilling to admit defeat, particularly, it seems, because they realize that any treatment program will involve total abstention from alcohol for the rest of their lives. They seem to regard this as an exorbitant price to pay, unless they have been brought to the point where they are convinced that they really have no choice. Perhaps authority in some form has spoken. Perhaps the wife (or husband) will no longer tolerate the situation and will otherwise demand a separation or a divorce. Perhaps the employer requires it; some large corporations now have company treatment programs for alcoholics, many of whom are very talented people whose services are highly valued.

[8] Clinebell, H. J. "Pastoral Counseling of the Alcoholic and His Family." in Catanzaro, R. J., *Alcoholism: The Total Treatment Approach.* Springfield, Ill.: C. C. Thomas, 1968.

Many times members of the alcoholic's family will approach the chaplain for help and advice, but the alcoholic himself refuses any help with his problem. In this instance, there is little that can be done except to advise the family to treat him as kindly as possible, but at the same time to deal with the situation in a realistic fashion. If he actually is ruining his health and reputation, and is in danger of losing his job, then it is in the best interests of everyone concerned to exert whatever pressure is available to get him to seek help. The best course of action will depend upon individual circumstances.

The chaplain may also put the family in touch with an Al-Anon Family Group. Association with other people who have the same problem in their families, talking with them and discussing their mutual concerns, is often quite helpful in assisting the family to deal with an alcoholic family member in a more understanding and effective manner.

The telephone directory of any metropolitan area will have a listing for Alcoholics Anonymous. A call to this number will provide information about both Alcoholics Anonymous meetings and those of Al-Anon Family Groups. It is best to become familiar with these community resources before the need to call on them arises. Then when they are needed no last-minute scurrying around is necessary. Another source of good information is *The National Clergy Conference on Alcoholism,* Box 1194, Indianapolis, Indiana 43162.

DRUG ADDICTION

Drug abuse has rapidly become a major problem in the United States, and especially in recent years among young people. One recent estimate, given by the White House Special Action Office on Drug Abuse, is 560,000. There was a sharp rise in incidence immediately following World War II, especially among teenagers, and more recently as an apparent reaction to the Vietnam War and other causes of social unrest. Between 1960 and 1967 juvenile arrests for drug abuse rose almost 800 per cent. Half those arrested for illicit use of narcotics were under 21. It has been estimated that several million American college students have at least experimented with marijuana, hashish, LSD, emphetamines, or barbiturates (President's Message on Narcotics to Congress, July

14, 1969). Intensive educational campaigns in high schools and in the mass media of communication have attempted to instruct potential abusers with regard to the disastrous consequences which may ensue from such thrill-seeking or anti-establishment behavior.

Groups Affected

Although found in all classes of people, drug addiction is more likely to be developed in adolescence or young adulthood, and by those who are of relatively unstable personality, or are subjected to greater than average social pressures, e.g., large minority groups, especially if subject to socio-economic deprivation. All grades of intelligence are represented, and all levels of education and socio-economic standing. As with alcoholism, more men than women become addicted to drugs, and probably for the same reason: the culture is more lenient with the failings of the male.

Addiction vs. Habituation

Addiction, strictly speaking, implies an irresistible compulsion to use a drug and so to obtain it in any way whatsoever, an increase in tolerance for the drug and therefore greater and greater doses with time, and a psychological and sometimes physiological dependence upon the drug's effects. Withdrawal from a drug to which a person is addicted always produces a genuine disturbance.

Habituation, on the other hand, does not involve an overpowering craving, even though the person may find that the drug produces very desirable effects and so develops a habit of seeking them. Inability to obtain the drug need not result in great physiological upset.

There is no sharp line of division between those drugs which are addictive and those which are habit-forming. Some individuals who smoke almost continually, or who drink large amounts of coffee every day, will usually experience not only psychological but also physiological disturbance when nicotine or caffeine is withdrawn. But these withdrawal symptoms are mild when compared with the major physiological upset which follows withdrawal from the opium derivatives.

Symptoms

These will vary according to the drugs used. Drugs which are commonly abused in the United States may be classified as follows:

1. Narcotics
2. Sedatives and depressants
3. Tranquilizers
4. Stimulants
5. Hallucinogens

1. *The Narcotics.*

These are usually the opium derivatives, principally morphine and heroin (junk, Harry, Horse, H, smack). Real addiction is usually developed to these.

The most common method of ingestion by addicts is by intravenous injection (mainlining). The immediate effects are depressant in nature: 1) feelings of drowsiness but with a clear mind; 2) decrease in voluntary movement; 3) lessening of the sex drive; 4) relief of pain; 5) euphoria and flight of imagination; 6) alteration of the concepts of time and distance.

Moderate amounts produce deep, dreamless sleep; a little more, coma; an overdose, death.

The continued use of opium derivatives results in the physiological adaptation of the organism to the drug so that larger and larger amounts are necessary to produce the usual effects. Eventually a point is reached where no amount of the drug produces euphoria, and large amounts are necessary even to keep the person comfortable.

True addiction develops after about 30 days. Then the drug is physiologically necessary for the user. Without it he suffers withdrawal symptoms: profuse perspiration, severe loss of appetite, restlessness, depression with feelings of impending doom, muscular weakness, increased respiration. As time passes these symptoms become more severe, and to them are added chills, vomiting, diarrhea, abdominal cramps, pains in the musculature, and tremors. Sometimes delirium and hallucinations occur, and in addition there may be severe cardiovascular collapse resulting in death.

If during these experiences morphine or heroin is injected, the subjective distress ends and the physiological symptoms disappear

within 30 minutes. If no drug is given, the symptoms increase in severity and reach their peak on or about the fourth day. They then gradually subside and have disappeared by the eighth day. By this time the person has begun to eat and drink normally, and tolerance for the drug has disappeared with the discontinuance of the withdrawal symptoms.

While an occasional individual may have sufficient control to take these drugs without interference with his life and work, most persons are unable to resist the physiological and psychological dependence which arises. All activity then gradually becomes centered around getting and taking the drug. A complete collapse of moral and social control results as the addict may be forced into criminal associations, petty thievery, the narcotics trade, or prostitution, to maintain the dosage necessary to keep him or her comfortable. Lack of adequate diet brings on ill health and higher susceptibility to disease. Eventually the police will probably catch up with the addict, who is then likely to be treated as a moral degenerate rather than as a sick person.

These ill effects are not due directly to the drug itself, but are the indirect effects of the demands addiction has made on its victims. They have had to give up food, social position, and self-respect, in order to get the money for the increasingly greater doses necessary to keep them comfortable. Wealthy persons, who have been able to continue adequate diets, have been able to maintain addiction for years without physical or mental illness due to the use of drugs.

In more recent years, synthetic substitutes for morphine have been developed, e.g., Demerol, Methadone, etc. Addictions to these, however, are not as frequent and are not so much a social and psychological problem as is addiction to heroin.

2. *The Sedatives and Depressants.*

Among these are Nembutol, Sodium amytal, Seconol, Luminal, etc. Abuse of these drugs has become a major social problem because of ease of prescription, and even availability without prescription. They are sought for their calming effects, their effectiveness for insomnia, and their ability to reduce anxiety and apprehension.

However, overdose results in an acute toxic reaction and even death. Their prolonged use induces dullness and lethargy and

eventually a deterioration of the personality. On the other hand, abrupt withdrawal after long and steady usage may result in severe convulsions. Eight to 12 hours after the last dose, some improvement occurs, but this is followed by nervousness, anxiety, tremors, muscles twitching, weakness, insomnia, and nausea. Mental confusion may also be experienced, along with hallucinations and delirium. This condition may continue for several days.

3. *The Tranquilizers.*

These are more recent discoveries, but are now in widespread use for reducing tension and anxiety because they are able to do so without greatly impairing the person's mental or physical functioning or causing sleepiness.

The major tranquilizers are the anti-psychotic drugs, such as phenothizine and the reserpine types. These seem not to cause any physiological dependence and they are not commonly abused.

The minor tranquilizers, such as meprobamate and chlordiazepoxide, do not affect the psychoses. They are chemically different from the major tranquilizers, but they are capable of anxiety and tension reduction, and some are used as muscle relaxants. They are abused occasionally. Their prolonged misuse produces effects and withdrawal symptoms similar to those which characterize the sedatives and depressants.

4. *The Stimulants.*

Cocaine (speed) was the usual stimulant abused until the development of the more powerful synthetics. Its first effects are dizziness, headache, and restlessness. These are quickly followed, however, by a state of euphoria lasting four to six hours, during which the person has feelings of peace, contentment, and a wealth of pleasant imagery.

With prolonged use, acute psychotic symptoms may occur, with disturbing hallucinations, not only visual and auditory, but especially tactile; the "cocaine bug," i.e., the sensation of bugs or worms crawling just beneath the surface of the skin.

Cocaine is a stimulant of higher brain centers, which induces sleeplessness, excitement, and sexual stimulation. Hence it has been used to overcome feelings of inadequacy, to give courage in stressful situations, and as a means of sexual seduction.

There is no physiological dependence on cocaine, since there are no serious withdrawal symptoms when the drug is discontinued. Tolerance does not build up, and the craving for the drug is psychological rather than physical.

There is habituation, however, in the sense that there is psychological dependence, so that the person's entire life is centered around obtaining and using the drug. Attendant upon this is loss of social status and self-respect, as well as petty thievery, prostitution and the like which have become necessary in order to maintain supplies.

The synthetics, such as benzedrine, dexadrine, the amphetamines (pep pills) are used to combat depression, and for the treatment of obesity, colds, and hay fever. They have the effect of lifting the spirits, raising the level of energy, and imparting a general feeling of well-being. There is no physiological dependence developed for these either, but psychological dependence can result from their prolonged use.

5. *The Hallucinogens.*

These have a legitimate use in research, but only rarely in clinical medicine at the present time. There has been some experimentation in their use for the treatment of alcoholism, in some cases with promising results.

Some hallucinogens have been known and used for centuries, e.g., mescaline, hashish, marijuana. Others are more recent developments, e.g., dimethyltryptomine (DMT), lysergic acid diethylemide (LSD).

As with cocaine, continued use of marijuana (pot) produces psychological rather than physiological dependence. Tolerance is not increased and there are no severe withdrawal symptoms. It is classified as a deliriant drug; i.e., it produces a form of delirium.

The drug itself is contained in the dried flowering tops and leaves of the hemp plant, which grows wild in many areas, and is not difficult to cultivate even in a slum backyard. Though these parts of the plant can be eaten, the usual way to use marijuana is by rolling the dried tops and leaves into cigarettes and smoking them.

Marijuana produces a feeling of extreme well-being, self-confi-

dence and relaxation with a lessening of inhibition and sometimes a sensation of floating on air. At the same time however, both intellectual and motor efficiency are decreased and time seems stretched out. The increased feelings of self-confidence, together with the lowering of intellectual and motor performance, probably account for many of the antisocial acts committed by "reefer" smokers.

Though it produces no physical ill effects of itself, the prolonged use of marijuana tends to produce dietary deficiencies, due to the expense of obtaining the drug, and a lowering of ethical standards. Prolonged use also results in a deterioration of the personality, psychotic-like episodes, crime, and amoral or antisocial acts.

Mescaline and hashish have similar effects.

LSD, however, is a much more powerful drug. Even small amounts produce gross hallucinations, changes in perception, in mood, in thought, and in activity. The senses are sharpened but distorted. Colors and sounds are intensified but changed in quality and extension. Words may be heard but not understood. Hallucinations of music and voices may occur, and there may be sensations of cold and of sweating. There may also be a feeling of lightheadedness, of emptiness, of lack of awareness of one's body, and of floating in air. Time is experienced in an erratic fashion; it slows, speeds up, stops, and even moves backward. A free flow of bizarre ideas occurs, and even minor experiences tend to seem greatly important.

Some have religious, inspirational, insightful experiences, but these effects are unpredictable. Not all persons have them, and the same person usually does not experience them on every "trip." A trip usually lasts from 4 to 12 hours, or longer. There may be delayed reactions, after the trip is over, which result in injury or suicide.

Research indicates that chromosome damage is found at least twice as often in LSD users as in non-users. Congenital and birth defects have also been found in infants whose mothers have been on LSD.

Dynamics

Although all ages, socio-economic conditions, races, religions, etc., are found among drug abusers, usually the dynamics are much the same. Misuse of drugs is a symptom of more widespread personality disturbances which might have shown themselves in other abnormal kinds of behavior.

In the vast majority of instances drug abuse grows out of:

1. the need to avoid tension and evade responsibilities; or
2. curiosity, peer pressure, and the seeking of thrills by teen-agers or young adults; or
3. accidental addiction as the result of prolonged medical treatment with a morphine derivative, a sedative or depressant, or a tranquilizer.

As to 1., this kind of personality cannot delay the immediate satisfaction of impulses and desires, lacks effective ethical controls, and constantly seeks new pleasures and satisfactions. Such a person runs away from anxiety and tension into the pleasant dream life provided by the drug. The psychiatric diagnosis is usually "immature personality."

2. Teen-age drug addiction is often found in otherwise normal boys and girls who have been associating with the wrong crowd, and who first take marijuana, under social pressure, because it is the thing to do. While under the influence of marijuana they are next introduced to heroin. As they are gradually "hooked" they withdraw from their other friends and go only with the addict-group, leaving aside all other interests, scholastic, athletic, and social.

Sometimes the need to belong to and identify with a "fast" and daring crowd stems from feelings of isolation and inadequacy, and from a need to revolt against adult society. Adolescents in fringe area minority groups are particularly liable to develop this type of reaction.

3. This accounts for fewer drug abusers in the U.S. than the other two categories. These are cases in which drugs have been administered at frequent intervals and over a long period of time, so that dependence on the drug has been established. Sometimes doctors and nurses, driven by curiosity and ease of access, find themselves dependent without really understanding how it came

about—they gradually drifted into it. They are usually adequate personalities, and once physical dependence is broken, no longer need or use the drug.

Treatment

This is similar to the treatment for alcoholism. The addict must be treated both physically and psychologically, and adequate treatment necessitates hospitalization, at least initially. The two principal hospitals devoted exclusively to this work are the Federal hospitals at Lexington, Ky., and Fort Worth, Texas. But now many of the larger hospitals in metropolitan areas have units for the treatment of drug addicts, and government sponsored and funded outpatient clinics are becoming more frequent.

The usual process of treatment includes: 1) withdrawal from the drug; 2) physical build-up of the patient's health; 3) prolonged psychotherapy so that the addict can learn to face and deal with his problems rather than run away from them.

What is likely to be the outcome of treatment? For young people who have succumbed to social pressure, and for those who have become accidentally addicted, the outlook is quite good. But for sociopathic personalities and for immature and egocentric individuals for whom the drug provides an escape from unpleasant reality, the prospects are distinctly unfavorable. Their purpose in submitting to treatment is mostly to decrease their tolerance so that they can get the effects they want with smaller and less expensive doses. As with alcoholism, cures can be effected only in those who sincerely want to be cured.

Nonetheless, the need for the rehabilitation of drug addicts is recognized by all the professions, even though agreement on methodology is far from universal. One approach advocated is the complete elimination of the person's addiction and prevention of its recurrence. Another would allow the addict to be maintained on the drug in order to eliminate the necessity for criminal behavior while the addict is receiving psychotherapy, vocational training, or both, when, as is usually the case, he is unable to overcome his craving for the drug.

In advocating the first approach Louria [9] has written:

> One can readily justify carefully controlled maintenance

[9] Louria, D. B. *Medical Tribune*, Sept. 4, 1965.

> studies, but how can the medical profession morally justify indiscriminate handouts of opiates? The addict is indeed sick, the vast majority being immature, frustrated hedonists who as one manifestation of their anger against society, suffer from chronic drug ingestion. Where else do we treat barbiturate or alcohol addiction in the same type of hedonistic individual by supplying barbiturates or alcohol?

He is of the opinion that rehabilitation can be best accomplished in camps where addicts work for pay and receive psychotherapy and vocational training as needed.

Representative of the second approach are methadone maintenance programs, such as that begun in 1964 at Manhattan General Hospital by Drs. Vincent P. Dole and Marie Nyswander.[10] These programs have since spread to almost every city in the United States with a sizeable addiction problem. Such programs are centered around the administration of a stable dose of methadone hydrochloride as a substitute for and an antagonist of heroin and the craving for it. Methadone produces no "high" effect, but it does prevent withdrawal symptoms, and really amounts to the substitution of addiction to methadone for addiction to heroin. These programs are reported to be meeting with moderate success, at least in the sense that addicts are socially rehabilitated and are able to hold jobs and assume family responsibilities. The ideal rehabilitation still remains to be accomplished, however; that is, the building up of the addict's personality so that he or she can cope with frustration and anxiety without resort to avoidance behavior.

The Role of the Chaplain

The drug addict usually has very little use for or commitment to religion. His commitment is to obtaining and using drugs to keep him comfortable, relaxed, and at ease. Some do have religious fetishes; they may wear crosses, or religious medals, or have a rosary strung aroung the neck. But they are not really serious about religion.

When addicts have committed themselves to being cured, however, they do feel the need for some sort of self-discipline. Then

[10] Dole, V. P., and Nyswander, M. A medical treatment for diacetylmorphine (Heroin) addiction. *J. Amer. Med. Assoc.*, 1965, *193*: 80–84.

they may turn to some more extreme form of religion, such as Yoga or Pentecostalism, and become quite fanatical about it.

The role of the chaplain in a drug program, therefore, is not a strictly religious one. He is not ministering to persons who feel much of a need for religion in their lives. But the chaplain does have a place. Addicts commonly feel they can trust the chaplain more than they can trust any of the other professional persons on the staff, almost as much as they trust one another or an ex-addict. They will confide in the chaplain more than they will in any of the other staff, even telling him when they have failed their commitment and started in again on drugs. Then his task is to persuade them to reveal this to the proper professional staff and take the consequences. Thus his role is to be a person who is open, warm, available, understanding, trustworthy, and supportive. He takes part in leading group psychotherapy, in staff conferences where patients are discussed and evaluated, and is ready as the one who will be understanding and worthy of trust when no one else is.

Chapter Eleven

PASTORAL CARE OF THE CONFINED

Alcuin E. Greenburg, O.S.B.

This chapter deals with pastoral care for patients who are held in legal confinement. The Church's concern for these patients has a double emphasis. The first is Christ-like concern for those suffering from illness. The other is the compassion of Christ Himself for those in confinement. Those who will give pastoral care, consequently, to patients in "jail wards" or "prison wings" of health care facilities will find their talents and skills doubly taxed. The paragraphs that follow are intended to be helpful by sharing experience, reflection, study, and dialogue from a survey of many who have already served in this special kind of pastoral care ministry. The reader should not anticipate definitive positions.

In developing its subject this treatment will move from the general to some of the more specific concerns for effective pastoral ministry in the confinement setting. A brief identification and discussion of some general difficulties for good pastoral care relations will come first. Some of the more common traumata of the patient will be covered next. The role of pastoral care as it applies to patient, staff members, family, and other pastors will be commented upon in practical terms. Finally, a brief comment will be made concerning pastoral care in the more permanent "prison hospital" setting.

Degrees of shock invade the life of every ill person who requires a form of hospitalization. When legal confinement is added to the circumstance of hospitalized illness, the effect is complex shock or trauma. The comments which follow are written in this frame of concern.

Loneliness of a special kind characterizes the emotional state of the patient in legal confinement. He is adrift from his normal, healthy feelings and activities. He is required to submit to procedures in the interest of cooperation with his doctors. New people are forced into his life—e.g., the doctor, the medical staff, and the confinement personnel. Very little of what was familiar to him is present now. Pastoral care's primary response is Christ-like presence in the moments of the patient's life. This presence brings a concern for this individual. This concern demonstrates a reverence for this person. This kind of presence witnesses an indestructible sense of God's welcome and Christ's warmth for this person who suffers.

To some people, pastoral care to the legally confined will appear as a straightforward matter. For others, however, some stumbling blocks appear to exist in the area of attitudes and emphases. Many of these interferences to good pastoral care can be managed by knowing about them beforehand and by a conscientious effort to manage them in circumstances where they do exist.

• *Too much concern for the details connected with the alleged or adjudged offense of the patient* can give the patient the wrong impression of the pastor's motives, and waste the pastor's time. The issue is the feelings of the patient and how the pastor relates to them. The goal of the relationship is for the patient to experience the genuineness of the presence in pastoral care of the person who has come to him in the name of Christ. If such an acceptance is achieved, the patient will reciprocate by sharing his feelings and even facts of his life and circumstances. Above all, pastoral care should not involve badgering the patient with a continuous series of so-called objective questions for data-gathering. If the patient is truly the center of pastoral concern, his present low self-esteem and feelings of social rejection command primary concern.

• *Treating the patient as someone special because of the circumstances that have placed him in confinement* gives the patient a good basis for "turning off." By the time the pastoral care personnel reach the patient, the patient is tired of being treated as someone special from a medical and confinement point of view. What he desires most of all is to be treated as himself here and now. In some ways this wish may express a form of denial of illness and confinement, but from the point of view of pastoral care see-

ing the patient as an ordinary person is the strongest basis for relationship and ministry. Sometimes the staff may reinforce the specialness of a particular patient: e.g., with the label of "dangerous." If the pastor cannot overcome the distraction of this label, then a straightforward investigation of the label (with a question like, "Do you want me to consider you as dangerous?") will begin a process of clearing the air.

• *Idle and self-serving curiosity about the patient's behavior* hinders good pastoral care. Such curiosity opposes rapport. Gossip-like curiosity erodes self-respect in the patient. The valid touchstone for all questioning must be patient-serving, essential, need-to-know concern.

• *Identification with local prejudgments of the "crime" involving the patient* makes good pastoral care impossible. Blessed is the pastoral care that comes without implicit or explicit local prejudice.

• *Anger with the patient for the evil he has committed* can get in the way of effective pastoral care. Persons responsible for pastoral care are expected to have high moral values and great concern for all people. Crimes offend against both. Since persons who perform pastoral care have feelings, too, they can be expected to be angry with compromises or attacks upon their principles. Such anger must not be even indirectly used against the patient if pastoral care is to be effective. The sin and the sinner must be distinguished for good pastoral care.

• *Putting the patient into a category with a label* confines him in a very uncomfortable position. While labels are necessary for sorting into broad areas for helpful responses, the patient needs constant reassurance of his personal identity. Unnecessary labeling has the contrary effect of throwing him into the limbo of the masses of people who are individually indistinguishable. Given the individual's patient status and his confinement, further labels are usually not needed to minister to this person.

• *Fear of what the patient might do* may be very real in specific cases. Such fears should be worked out in discussion with the professional staff of the health care facilities and/or confinement personnel before a visit is attempted with the patient. Straightforward questioning of the staff about grounds for personal fear is very appropriate. In such exchanges with staff members pastoral care

personnel can learn to anticipate the actions of patients who may thrash about in their beds, shout angrily at the visitor, and so on. The advice of the professional staff should be carefully accepted and used. As a general rule, pastoral care personnel should know that while they may experience some fear, the patient is normally fearful in his own right in the hospital and confinement setting. The vicious and circular game of fear begetting fear should not involve gamesmen engaged in pastoral care.

The confined patient experiences shocks. Some of these traumata are rather commonplace and allow for generalization.

• *"Caught" in illegal activity.* The conditioning of Americans is based on a classical concept of penal law. To be caught in violation of a penal law is to be humiliated in a special way. Confinement sustains this identification for the patient.

• *Accused by all society.* "Everybody is against me" summarizes the patient's feelings. The impersonality of the law reinforces these feelings. Law-enforcement personnel have a seeming facelessness that can confirm these feelings. Absoluteness gains reinforcement from monolithic manifestations of the law which has brought about the confinement.

• *Forced management of physical needs.* The confined patient is peppered with new experiences. Health treatment routines are demanding in their own right. The physical control and accountability demanded by confinement impose still more demands. In a very real and physical sense, the patient is not his own master in this setting.

• *Confusion in identifying sources of pain and sources of relief from pain.* In some illnesses the patient can be presumed to be in pain. Some pain cannot be relieved, while other pain can be relieved for only a short period of time. Normally the patient is not able to sort out these two categories of pain; and in the case of pain that can be relieved the patient may identify the recurrence of the pain as the doctor's "fault" or the guard's "fault" for not letting the medical personnel administer relief that has been ordered.

• *Fear at the impotence that requires him to depend upon clearly non-medical personnel to care for his life.* The patient is shocked to have to let some one else care for him. He is severely

shocked to have to allow law enforcement personnel to administer care for his life. Such enforced dependency can extend from getting a light for a cigarette through the use of bed pans and urinals to simply depending on the alertness of the guard "should anything go wrong" with the routines touching the patient's life.

• *Shock from the sudden and stigmatized interruption of routine living.* Fixed visiting hours, screening of visitors, monitoring of visits, and interruption of normal communications are among the sources of the shock the patient experiences. The patient also labors under some fear that his family and friends will be stigmatized because of his present situation.

• *Serious demand for precise and consistent communications.* Frequently the patient will be asked, with all due protection of law, to make statements and give information about his activities and circumstances that preceded and led up to his need for care in the health care facility. The specific purpose of these questions, the role of the questioners, and just what use will be made of the information are all vague to the patient. All this is disconcerting to him.

• *Fear of the medical personnel's reaction against the crime that has been committed.* The patient can develop a fear of the medical staff's reaction against him for the crime that has placed him in confinement. The normal stresses of being caught by the law, the humiliation of the confinement process, and some ignorance of the professional qualifications of the staff combine to increase the patient's fear. Practically, this fear appears in questions like, "Does the doctor hurt me because he has to or is he 'mad' at me too?"

• *Inability to communicate as clearly as the patient would like.* Necessary medications may leave the patient in a slumber and not as alert as he would like to be. In this twilight state the patient can recognize his lack of complete control as well as the fact that he cannot do anything about it. He feels special fear at this point.

To summarize the effect of the preceding influences on the patient, the confined patient can be visualized as the focus of a threefold attack. One thrust of the attack is the novelty forced upon him: viz., persons, routines for doing things, and dependencies—all part of the medical and confinement picture. A second

attack is directed at his personal dignity resulting from his almost absolute loss of privacy and from the fact that he is categorized and not treated as an individual. The last offensive comes against his personal identity in the form of the applications of the law, broad categories of medical treatment planning and procedures, and in the denial of his individual ability to manage detailed aspects of his own life.

Procedures are important for effective pastoral care to the confined patient. The physical control of the patient is the responsibility of the confinement personnel. These may be a police guard or a group of custody agents. The person performing pastoral care must respect this responsibility and the structures that it begets. He must check with the custody personnel and follow the routines they have established. Within this framework, pastoral care can be realistic and spontaneous. Normally any item to be shared with the patient should be ready for prior inspection by and explanation to the confinement personnel. The same is true of items that the patient may want carried from the confinement area, such as letters. This point must be made clear to the patient before the items are accepted for possible delivery from the confinement area to avoid accusations of compromise later. The ministry of pastoral care is well served and efficiently reinforced once the custody personnel are persuaded that those active in pastoral care are understanding and cooperative.

The patient is not the only focus of attention for pastoral care. He is the primary focus; but in the interest of total patient care as well as maximum effectiveness of pastoral ministry, others who come into contact with the patient have a relationship to those who minister pastoral care. First some further comments on the pastoral care role as it applies to the confined patient; and then a few summary remarks about the pastoral care role in relation to others.

Good pastoral care for the confined patient is made up of several common elements. As many as possible of the negative and blocking attitudes cited in the first part of this chapter must be eliminated or at least minimized. The patient must be accepted as he is, with his complexus of fears and uncertainties. Genuine concern for this patient reduces fear and gives reinforcement. Realism is then served by the relationship. The patient can be kept in contact with the real graveness and the painful uncertainties of his situation with an honesty that manifests the truth of Christ. No patient

in confinement is done a service by being allowed to escape into the "what-if" world or denial of realities. The realities of the patient's medical condition (within the norms established by the medical care personnel) as well as his status before the law (however severe) must face him as part of a genuine encounter predicated on the openness and support of true pastoral care. How pastoral care develops will reflect the personalities of the patient and the personnel providing the pastoral care. If the role is developed as outlined here, the presence of Christ in the pastoral care of the confined patient will be easily recognized.

Medical treatment and staff personnel are under special stresses in caring for the confined patient. The details of physical security of the patient are an additional factor in the established procedures. Annoyances can result from this complication. Some of this annoyance may be transferred to the patient. Pastoral care can do a great service by accepting all the elements of the situation. Such reinforcement is largely given by example (lack of personal manifestations of irritation with requirements), openness to listening and reinforcing the rightness of the professional roles, and sorting out the incongruities of the setting. A person providing pastoral care can be an informal but effective arbitrator between the medical and custody personnel and the confined patient.

Next to caring for the patient, the most demanding role in pastoral care may be the relationship with the family of the patient. The family's normal reactions may include guilt, agitated concern, shock, and anticipatory doom, depending on the illness and/or the legal situation of the patient. Pastoral care calls for consistent and gentle insistence on realities as these apply to the circumstances of the individual members of the family group. Dealing with the family is a complex matter and can be expected to be the most time-consuming of all the activities in total ministry to the patient. The time, however, is well invested. But ministering to the family can involve many frustrations for the pastoral care personnel. These frustrations must be identified as soon as possible and worked through so that they are not projected onto the patient or members of the treatment and custody teams.

Finally, pastors of the patient and the patient's family have rightful expectations of the pastoral care personnel. They will want

to know the patient's condition, what has been done to provide spiritual and pastoral care, and perhaps details concerning their visiting the patient. Normally, effective pastoral care calls for anticipating the questions of patients' pastors and having clear and ready information available. In specific cases it may be well to extend an invitation for specific ministration. In cases where the patient will be transferred to a confinement institution, a prepared résumé of what has been done with and for the patient in the way of pastoral care can assist the institutional chaplaincy personnel to continue efforts undertaken in the health care facility.

Pastoral care in the prison hospital setting differs from what has already been presented mainly in regard to matters of time. Normally, in the non-prison hospital pastoral care must be "hurried" because the patient is not going to be there long. In the prison hospital, however, the patient will normally have some sort of calendar sentence or assignment that will give the pastoral care personnel time to plan their relationships with the patient and the agenda he may wish to follow. Otherwise, the considerations set forth above and elsewhere in this manual apply in the prison hospital setting.

Chapter Twelve

THE CHAPLAIN AS EDUCATOR

John A. Howe, O. Carm.

Christ came into the world to teach all men the way of salvation, which consists in possessing the fullness of human life (John 10:10). Today, more than ever before, man understands salvation in terms of the full development of the human spirit, though he may refer to it as "spiritual health." Spiritual health is synonymous with the biblical terms "wholeness" and "holiness," which signify the fulfillment of human potentialities for living a constructive life in mutually satisfying, loving relationships. This is the gospel message of Christ, the message he commissioned his disciples to teach all men.

As a minister of Christ's gospel, the hospital chaplain participates in the healing ministry of Christ among his people. His primary function is to exercise a healing influence upon the human spirit (understood in its most comprehensive sense), and to teach others how to achieve spiritual health and happiness.

Spiritual health—as it is revealed in the Bible—is associated with the process of moving *toward* (as distinguished from moving *away from* or *against*) other people and cooperating with others in building communities of fellowship, love and service. The primary role of the minister of Christ is to lead the way in this task of building Christian community.

The remainder of this chapter will suggest ways in which the hospital chaplain can teach the gospel message in his relationships with patients, the hospital staff, and the local community.

A. *The Chaplain and the Patient*

Spiritual health requires healthy relationships with God and one's neighbor. The more fruitful relationships a man experiences,

the more will he experience the saving, healing action of God in his life. This is an area in which the chaplain can be of considerable help to the patients he serves.

On being admitted to a hospital the patient experiences himself as a stranger in a foreign land. He feels anxious, alone and relatively helpless. It is at this time that "a friend in need is a friend indeed." The chaplain is well-suited to fill the role of the Good Samaritan. He can welcome the patient to his community of fellowship and service; he can allay the patient's fears about accommodating himself to the hospital environment; he can reassure the patient that others are concerned for his physical and spiritual health.

At this time the patient feels a deep need to relate to another person who really cares for him and shows sincere sympathy for his condition. Thus it is important for the chaplain to meet the patient "where he's really at" and to relate to him in a totally human manner, trying to discern his feelings and identify with them.

Illness is often a time of personal crisis. It can also be a time for conversion to a new life of spiritual growth. In such cases, the chaplain's human understanding, sympathy and support can be very therapeutic for the patient's spiritual condition.

Besides relating to the patient in a deeply personal way, the chaplain can also help the patient see and experience the value of looking beyond himself and relating constructively to others. Very often illness makes a person more turned in on himself and preoccupied with his problems. His interest in and concern for the people around him tend to be restricted. He is inclined to see himself unrealistically as the center of the universe and, consequently, to make unrealistic demands on those around him. In such cases, the chaplain can be of service in re-orienting the patient's perspective and correcting his attitudes toward those around him.

The chaplain can also render a valuable service by educating patients in the art of loving, helping and healing each other. Very often the most serious handicap of illness is the psychological experience of loneliness and boredom. People who are used to leading very active lives are most susceptible to a kind of spiritual malaise, for they are at a loss to find enough ways to fill up their

leisure time profitably. The chaplain can initiate a spiritually healing process by motivating the patients to draw upon their latent resources for mutual help and recreation. Patients who become actively involved are progressing along the road to spiritual health.

For patients undergoing a long process of recuperation, some forms of group therapy can be very helpful: for example, discussion groups conducted by patients who share common problems, concerns and interests. The chaplain can be instrumental in stimulating the patients' interest and initiative in organizing such projects for their mutual benefit.

These are just a few ways in which the chaplain can be effective as a teacher of the gospel message. Like Paul, the chaplain should see himself as a leader in the missionary work of building up the Christian community of fellowship and service. By his example he should be able to show the way to others and inspire others to follow his lead.

B. *The Chaplain and the Hospital Staff*

The chaplain's effectiveness in establishing spiritually healing relationships with his patients will be conditioned, to a greater or lesser extent, by his ability to establish good working relationships with the members of the hospital staff and with all para-medical people who are involved in the process of helping the patient.

Today we are more inclined than in the past to agree with John Donne's view that "no man is an island entire of himself . . . we are all a piece of the continent, a part of the main." In the health field, the team concept is universally accepted as the model for offering the most effective help to those in need. Each member of the team has his own contribution to make to the healing process. The team model in medicine is compatible with the church model in theology. As Paul expresses it:

> Men have different gifts, but it is the same Spirit who gives them. There are different ways of serving God, but it is the same Lord who is served. God works through different men in different ways, but it is the same God who achieves his purpose through them all. Each man is given his gift by the Spirit that he may use it for the common good. (I Cor. 12:4-7)

In the light of Paul's vision, the chaplain should be quite ready and willing *to see himself* as a part of the whole healing process in the hospital where he serves. Once the chaplain accepts himself in this auxiliary role, he will be able to help the members of the hospital staff to see the chaplain's unique contribution.

The priest has been traditionally accepted as a mediator between man and God. Without obscuring this relationship, the priest today must also show himself to be a mediator, a reconciler, between man and his neighbor—since the first two commandments are inseparable in their application. This is, perhaps, the most important truth that the priest has to teach people today. His ability to teach it effectively will largely determine his effectiveness as a priest.

In his relationships with the hospital staff, the chaplain should see himself as a professional person, *cooperating* with other professionals in the process of offering healing service to the sick. Man is seen today as a complex human being with multiple interrelated needs. The physical, psychological, religious, and sociological dimensions are interrelated parts of the total human person. To neglect one dimension is to endanger the others. Thus the chaplain should be able to accept with humility the fact that he plays a vital but nevertheless limited role in the total healing process.

When the chaplain sees himself as a member of the hospital team, he can begin to help the other members of the team see him in this role. Most doctors and nurses know that the chaplain can be a helpful liaison between the medical staff and the patient and his family. Very often they will call upon him to communicate information of a critical nature to a patient and/or his family and to offer them spiritual support.

But the chaplain's value to the staff can be much more extensive. He can also be a mediator between members of the staff, a builder of a community of interpersonal fellowship and cooperative service. The chaplain usually enjoys a position of trust and respect; he is regarded as one who represents the values of God to men. His position can be strengthened considerably if he shows himself committed to promoting the values of human understanding, sympathy and cooperation among his fellow workers.

What we envision here is the chaplain as a kind of spiritual "good will ambassador" who produces healing effects on his associates. In his position of trust and respect, the chaplain learns rather quickly about personal frictions and professional jealousies that crop up among members of the staff from time to time. Such problems, if allowed to become serious, can have a detrimental effect on the morale of the staff. Before this happens, the chaplain, in his role as mediator and reconciler, may be able to explore with tact and discretion the possibilities of bringing about a reconciliation. As one who can command respect and trust, the chaplain may be the person most qualified to generate mutual respect and trust among the other members of the staff, and to bring them closer together in the cooperative effort of offering healing service.

The members of the staff have the problems and weaknesses of all human beings. They are prone to succumb to the weariness of well-doing. They can run short of patience and understanding. They fall prey to the pressures of having almost superhuman demands placed on them. In trying to cope with these human problems, staff members can be greatly helped by someone who understands and sympathizes with them. If the chaplain is such a healing person and can encourage others to follow his lead, he can be an invaluable helping agent to those professionally involved in the healing process.

The more effective the chaplain is as a helping agent for the staff, the more effective will he be as a helping agent for his patients. If he has established good working relationships with the members of the staff, he can be an effective mediator between patients and staff. He will be better able to help them understand and sympathize with each other's problems, thus reducing, to some extent, the areas of stress and friction that normally develop from a lack of mutual understanding and sympathy.

The chaplain should be the member of the staff best qualified, by his vocation, training and personal commitment, to heal the wounds that men inflict on each other; and to teach others, by his example, to do likewise. In this capacity, he can be an invaluable asset to a group of professionals committed to the healing process.

C. *The Chaplain and the Local Community*

The chaplain is potentially a healing agent not only for the patients and the hospital staff, but also for the local community. By drawing upon the resources of the local community and bringing them into contact with the hospital community, the chaplain fulfills another aspect of his role as community builder. Very often the resources of the local community—both clerical and lay—remain untapped by the hospital community. In such a situation, there is a need for someone to act as bridge builder between those who can help and those who can be helped.

By virtue of his office as mediator, the chaplain is best suited to fulfill this role. But to be an effective liaison, the chaplain must be in active personal contact with both communities. He must know who are the people "out there" who are able and willing to help the people "in here."

The resources of local churches are the first to be explored by the chaplain. Many churches are interested in being of service to those in need in their community. Many members of these churches are eager to be helpful to those in need of help, but very often they do not find an adequate outlet for their zeal. They need someone to direct their energies into productive channels of apostolic expression. The hospital chaplain can do this.

Many services are needed for the benefit of hospital patients; and many of these services can be supplied by willing members of local church communities. What are some of these much needed services?

First, many patients need personal companionship. Elderly and isolated patients are especially likely to be bereft of family and friends, and would welcome the opportunity to experience the personal concern and companionship of a fellow human being.

Although these patients may be receiving the best physical care that the hospital can provide, that is very often not enough. As Gordon Allport has stated: the best therapy consists in the personal interactions that take place between human beings who are mutually concerned for each other's well being. Contemporary psychology and theology underscore the fact that interpersonal relationships are *mutually* beneficial to those involved. Thus social service today is no longer seen as the "haves" ministering to the

"have nots." To give is not *better* than to receive: giving and receiving are complementary sides of the same coin of human love.

Another kind of service which hospital patients badly need is recreation and entertainment. The ability of patients to recreate and entertain themselves is often very limited. Parish societies might be enlisted to supply forms of recreation and entertainment (both inside and outside the hospital).

Local seminarians might also be recruited to volunteer their services for the patients. They can, for instance, conduct seminars and study groups, geared to the interest and ability of the patients; or direct prayer services of the Pentecostal type, which emphasize the healing power of the Spirit; or lead song fests and sing-alongs, designed to involve the patients in active participation.

These are only a few of the needed forms of service. The specific needs of the hospital community, as well as the specific resources of the local community, will determine the practical possibilities. Whatever the resources, they can be actualized only by a co-ordinator who is in personal contact with the needs of the patients and the available resources of the local community. The chaplain should be willing and able to carry out this function, which can provide invaluable benefits for the spiritual health of those to whom he ministers.

Conclusion

The chaplain has immense opportunities as an educator in the field of healing service. His training and personal experience fit him more than adequately to be a healing person and to train others in the art of healing the human spirit. His task in the Church is to carry on the healing mission of Christ among men. To the extent that he is instrumental in uplifting the human spirit and teaches others to do likewise, he will fulfill himself as a priest, a teacher and a person.

Chapter Thirteen

THE CHAPLAIN SUPERVISOR

John A. Howe, O. Carm. **Walter J. Smith, Ph.D.**

> "Seminarians need to learn the art of exercising the apostolate not only in theory but in practice. They have to be able to pursue their assignments both on their own initiative and in concert with others. Hence, even during holidays, they should be introduced into pastoral practice by appropriate undertakings. Depending on the age of the seminarians and the local conditions, and given the prudent approval of their bishops, such programs should be pursued in a methodical way and under the guidance of men experienced in pastoral matters."
>
> Vatican II—*Decree on Priestly Formation*, n. 21

Clinical pastoral education is designed to provide such programs. Pastoral field placements enable students, whether ordained clergy or seminarians, to take part in "on the job training" which places them into situations involving the problems and tasks of real ministerial life. There they can learn to use their intelligence and their training to develop some of the practical skills they will need in their ministry, and to bring back to the classroom for discussion some of the personal experiences and problems which they have encountered.

The practice of "on the job training" is really nothing new in the Church. In the early days of Christianity the education of men for the pastoral ministry was accomplished by means of the personal association of the "trainee" with a presbyter or bishop currently engaged in the active pastoral ministry. This is how the apostles prepared their successors, and also provided spiritual leaders for the growing Church as it expanded into the local communities in all sections of the Roman Empire.

During the Middle Ages and later, education for the pastoral ministry became more academically oriented. This strengthening of the academic program led to a gradual diminishing of practical work experience in seminary education. It was the Second Vatican Council which tried to re-establish a balance between the theoretical and the practical by insisting that pastoral concerns should "permeate" the entire seminary program. (*Decree on Priestly Formation,* n. 19)

In 1970 the Sacred Congregation for Catholic Education published *The Basic Plan for Priestly Formation* which insisted that "practical works of the apostolate" should supplement the academic program "throughout the whole of the scholastic year, as well as in vacation time." (n. 97) This document went on to specify the kinds of activities meant: "for instance, giving religious instructions, taking an active part on feast-days in the parish liturgy, visiting the sick, the poor, prisoners, helping priests engaged in youth-work, etc." It added that these experiences should take place "under the direction of experts and wise priests who will assign each one his work, teaching them how to go about it, be at hand while the work is being done, and arrange for a review of its performance afterwards with the students in order that they may reflect on what the experience has taught them and receive effective advice." (n. 98)

It is apparent from this that the pastoral setting in which students are placed should provide a supervised learning experience, from which they learn about the ongoing day-to-day operations of the parish or institution. It should give them opportunities to show initiative, leadership, and creativity, and to grow in awareness of what they can do well and what they are less good at, of the aspects of pastoral life they find exciting and challenging as well as those for which they feel some distaste.

Supervision requires guidance and direction. It involves a personal relationship between a supervisor and his student in a learning situation. It is an educational process whereby an ordained clergyman or seminarian learns the practical skills needed to minister to people under the guidance and direction of an experienced, mature, astute and sensitive pastoral supervisor.

Thus, there are three elements involved in supervision: 1) supervisor, 2) students, and 3) a learning situation. These three ele-

ments interact to foster the growth of both students and supervisor in understanding their roles in the ministry in which they are currently involved.

1. *The Chaplain Supervisor.*

The Chaplain Supervisor must show genuine concern for his students' learning and growth. Hence he must provide them with both direction and challenging experiences in accord with their backgrounds and capabilities. He must himself be a mature person who has solved the problems of his own identity; otherwise he will be unable to help his students resolve their identity problems. He must have established himself as a successful chaplain and be recognized as such by the hospital community. In addition, he must be willing to establish close working relationships with student chaplain trainees. Finally, he ought to have, in addition to his professional skills, the ability to communicate a theological understanding of the role of a chaplain in the treatment of the sick.

While the supervisor should play an active part in planning the students' work, he should do so by consulting with him, so that the program will be satisfactory to both. Students also must clearly understand that they are responsible to the supervisor, that they are to report to him for work, and that he will always be available to them for consultation and problem-solving.

It should be clear from the outset what is expected of the chaplain trainees in the particular hospital. At the first meeting of supervisor and trainees, the students should be told the duties they will be expected to assume and exactly what role each chaplain on the staff will play as far as their experience at the hospital is concerned. Each student should know not only where he fits into the total picture, but also where every other trainee and staff member fits.

While the students will have many needs in common, there will also be individual differences among them. The supervisor should be aware of each trainee's experience and his particular needs with regard to education and supervision. Ideally, each trainee's placement experience should be tailored to his educational and work experience and to his individual need for further academic and practical training.

2. *The Students.*

Each student, for his part, should think of his work as a hospital chaplain in terms of his identity as a minister of the gospel. He should attempt to situate for himself hospital chaplaincy in the total ministry of the Church.

To do this well, he will need assistance and guidance. If he has already had a field placement in another area of ministry, this will give him some degree of confidence in his approach to patients, even though new demands are likely to be made upon him in the hospital. Such a student will probably require less preparation and guidance than one for whom the hospital is his first field placement.

Occasionally students are unable to recognize the limits of their competence. Because they have done well academically, they feel overly assured in their field placements and less in need of guidance and instruction. One of the tasks of the supervisor is to deal with these attitudes and feelings in the supervisory relationship.

Such a confrontation will probably best be handled in individual meetings between trainee and supervisor. There should be time each week for these individual consultations. On these occasions discussion of the trainee's experiences and an evaluation of his progress should take place. Both student and supervisor should have their say at these meetings.

No matter how closely supervised, every trainee must sometimes assume individual responsibility for his judgments and behavior. No one can foresee and prepare a student for every possible kind of encounter. Hence each student ought to be assisted to be continually aware of what he is doing, to ask himself why he is doing it, and to evaluate how he is doing it.

The purpose of a field placement in a hospital setting is not to awaken a new set of values in a student. It is rather to make his value system explicit and conscious as he applies it to hospital work. Individual intellectual, emotional, spiritual and moral growth through working with people in life crises should be the outcome for each trainee in a hospital field placement.

3. *The Situation.*

The setting must be one in which the processes described above

can take place. The program for hospital chaplain trainees must have not only the approval, but also the cooperation and encouragement of the administration and of each of the departments which will be called upon to take part in the educational process.

In addition, the setting should challenge the intellectual and experiential resources of each trainee. Here he should meet new problems, different personalities, persons in desperate need. He must learn to respond appropriately to all of these challenges. The situation must also provide him with feedback, not only from his own supervisor, but also from the other chaplains, the other professional persons with whom he works, and the patients whose needs he serves.

Finally, the placement should afford the trainees opportunity to exercise co-responsibility with the chaplains and other professional persons in multi-disciplinary patient care, where there is real need for the trainees' work. They should not do "busy work" but should have opportunity to make a real contribution to satisfying needs of the patients.

The Process of Clinical Supervision

The word "clinical" in our society frequently suggests illness. This is not the meaning intended here. "Clinical" is meant rather to convey the notion of face-to-face relationships between supervisor and trainee, rather than supervision from a distance—somewhat removed from the scene of action. "Clinical" supervision, therefore, is supervision "up close" to the activity being supervised.

This does not exclude group supervision, such as supervision of individual trainees by a number of supervisors, or of a group of trainees by one supervisor, or even of groups of trainees by groups of supervisors. Each of these can take place by means of face-to-face contacts.

"Clinical" supervision also implies overseeing actual professional behavior. What the trainee *does* is what is supervised. This means that his behavior, his interaction with patients and staff, must be observed, and the observational data must later become the material for supervisory conferences.

If improvement of patient care by Chaplain Service is an impor-

tant goal of clinical supervision, and if improved patient care is an objective of all chaplains in the hospital setting, then the means taken to achieve this goal must include a great deal of patience and compassion and a profound realization of what one's own behavior is like and how it affects other persons. Assuredly, this is difficult to achieve, but any failure on the part of either chaplain supervisors or trainees to be patient, compassionate, and insightful, will involve a measure of self-defeat.

On the other hand, the goals of clinical supervision will be achieved when, through the sincere striving of all involved, every chaplain and chaplain trainee is more fully aware of why he is working in the hospital, has a greater need to be and work there, and has the satisfaction of realizing that by working with others in the clinical supervision situation, he himself is developing into a better person while he also tries to improve the lives of those whom the hospital serves.

The process of clinical supervision may be thought of in five stages:

1. Initial Conference,
2. Observations,
3. Analyses and Strategies,
4. Supervisory Conferences,
5. Final Evaluation.

1. *The Initial Conference*

The purpose of the initial conference is to provide the framework within which the supervised experience is to take place. During this conference communication between trainee and supervisor should be established. This can perhaps best be done if they first find out some important information about one another. Each should tell the other his educational background and give a summary of his experience. They should try to learn to talk together in a relaxed and comfortable fashion.

Their conversation at the initial conference should concern what each expects of the program. The trainee should be encouraged to tell why he has sought a hospital placement for his field experience and what he expects from it as far as his training for the ministry is concerned. The supervisor should state what he expects from the trainee with regard to his attendance at the didactic lec-

tures and group seminars provided by the program, and also on which hospital units he believes the trainee would be likely to learn most about hospital chaplaincy work.

After they have come to a meeting of minds, so that both expect the same things from the program, they should draw up a supervisor-trainee contract in which they reach explicit agreement about what the trainee will be doing, at which times each week he will be doing it, and when the weekly supervisory conferences will occur. A copy of the contract should be retained by each party, and a third copy sent to the Director of Field Education at the seminary.

2. *Observations*

Observations, analyses and strategies, and supervisory conferences will be taking place continually and close together over the weeks of the placement.

The purpose of observation is that the supervisor find out what happens as each trainee interacts with patients and staff, so that he can talk to the trainee about it afterwards during the supervision conference. He should generally write down what he sees and hears, and as comprehensively as he can, so that he has an accurate record and does not need to depend on his memory. It is important that his account be true, accurate and complete, so that it represents what actually happened. The use of tape recordings of sessions with patients contributes to accuracy.

One reason for the supervisor to observe is that, while doing his chaplaincy work, the trainee is not able to observe his interactions in that same way that a disengaged chaplain supervisor can. Another reason is to show his interest in what the trainee is doing by paying close attention to his behavior. A third reason is to detect the existence of any problems which the trainee encounters in his interactions with patients and staff. These problems need not indicate weaknesses or anything bad, but may simply lead to discussion of whether some other approach to the patient or staff member involved might not have been in some way more friendly or productive of patient welfare, etc.

Another benefit of observation is that it may help the supervisor obtain insight into how his own performance can be improved.

Finally, observation should afford opportunities for both trainees and supervisor to test reality with regard to their interactions with

patients and staff. Supervision should result in the gradual increase in autonomy in the trainee, i.e., in greater and greater capacity for independent, objective analysis of his own behavior. The supervision is faulty if it increases the trainee's dependence on the supervisor for assessment.

3. *Analysis and Strategies*

Analysis and Strategies have two general purposes: to make the observational data intelligible and manageable, and to plan the manner in which the supervisory conference will be conducted, i.e., which issues will be treated, which supporting data will be cited, which goals will be discussed, where the conference will begin, and where it will end.

It is a common mistake in chaplain supervision to observe trainee behavior and either deal with it on the spot—in front of patients or staff—or later in the office but informally, or (if the supervisor really wants to "cop out") in a written memo. There is also always a tendency to supervise in the same fashion as the chaplain supervisor was himself supervised. This is mere mimicry. Good supervision is not caught in the snares of the past, but is alert to new methods and inventive.

The supervisor should provide trainees with opportunities to participate actively in the evaluation process. They should be encouraged, during the supervision conference, to evaluate their own actions, particularly the ways in which they have related to patients and professional staff. If something has gone wrong in an interpersonal relationship, it is good to encourage them to try to determine the reason, to discover for themselves what they may have said or done which led to the deterioration of the relationship. The supervisor should not simply state the reason and expect the trainee to accept it uncritically.

Another hazard is supervision which is punitive or felt as such by the trainee. In such cases what the student learns—for his own protection—is how to second-guess the supervisor, how to stage performances which will please him, and how to get on his good side in various other ways.

Supervision should be an essentially rational procedure, using methods of logical reasoning and honest analysis. It should not

be in any way mysterious or devious, for then trainees will mistrust it and tend to be anxious about it rather than profit by it.

Supervision of present interaction with patients and staff seeks to foster understanding what actually took place, to correct whatever needs correction, and thereby to make future interactions productive of better patient care, conducive to better staff relationships, and more pleasant for everyone involved.

A supervisor should be ready to give the evidence for his conclusions about the trainee's behavior, his questions or judgments concerning it. His process of reasoning should be open to examination, and perhaps refutation, by the trainee, in case it contains logical inconsistencies, or the supervisor is not in possession of the facts.

In addition, careful analysis of trainee behavior should manifest the interest and commitment of the supervisor to the trainee's welfare and progress. Analysis as a method of supervision is a means of learning and of modifying and improving trainee conduct.

After the supervisor has analyzed his observational data, his next task is to decide how he will conduct the supervision conference. He may of course choose not to structure anything in advance of conference time, but to use a more free-wheeling approach with no specific focus on any particular trainee behavior which he has observed. However, the rationale for having a Strategy is that a planned approach is more likely to be successful than a random one. If the Strategy is good, it should lead to conduct which the trainee himself finds more useful and satisfying.

It is usually safe to assume that the trainee's placement experience is important to him. He is there because he wishes to profit from it. Observation and analysis of his behavior and discussions of ways in which he can improve will be important to him because he will see them as beneficial and in his own interest.

Strategy is important also in that it may help to avoid hurt feelings. If trainees come from the conference feeling damaged by supervision, it has been unsuccessful. Careful preparation of the supervision conference is in the interest of the supervisor as well as of the trainee.

Strategy has the additional purpose of providing continuity to the supervisory process. It should be designed to foster growth in trainee effectiveness during the entire period of the placement.

Finally, trainees are more likely to have confidence in the worth of supervision when they know that the supervision has spent some time preparing for the supervisory conference rather than simply playing it by ear. If the supervision is going well, trainees will be relaxed, functioning intelligently, committed to their work, creative, and self-directed. This is more likely when they also have time to prepare their own strategies for the supervision conference. Then they do not have the disadvantage of being confronted, completely unprepared, with material already thoroughly familiar to the supervisor.

4. *Supervisory Conferences*

Supervisory conferences are the most important component of supervision. While it may sometimes be appropriate to omit the preparatory stages for good reasons, adequate supervision does not take place without a series of supervision conferences. Some kind of conference is always preferable to no conference at all, if only to show the interest of the supervisor in the work of the trainee.

Even if the trainee's performance has been very poor, it is less damaging and hurtful to deal with the problem in the supervisory conference than to omit the conference. In the latter case, the trainee will have only his own imaginings to tell him how the supervisor is reacting to the undesirable conduct. In short, unless a supervisor is willing to engage in a series of supervisory conferences with his trainees, he should not attempt to do supervision.

The supervisory conference is intended to give the trainee the opportunity to engage in an analysis of his own behavior through conversation with someone more experienced who has observed his conduct. During the conference the trainee has the opportunity to think about what he has been doing, and to make realistic decisions about methods of improving his behavior.

In more specific terms, the supervisory conference should:

1. Provide a time to plan future patient and staff interactions in collaboration with an experienced professional chaplain; it should leave the trainee with some concrete design for his next contact with patients.
2. Give opportunity to redefine the process of supervision, i.e.,

to take a new direction when it seems appropriate, or to use a different method.

3. Provide the trainee with rewarding feedback, by which his contribution to patient care is acknowledged and praised by an experienced chaplain.

4. Discuss problem areas in the multi-disciplinary treatment of patients, such as relationships with other staff members, and with the families of patients.

5. Educate the trainee in techniques of self-supervision and of professional self-analysis.

6. Deal with any factors which might affect the trainee's general vocational satisfaction, as well as his specific feelings about his competence as a chaplain trainee.

5. *Final Evaluation*

This is really the final supervisory conference, and it involves each trainee with his supervisor alone to discuss and assess his progress, successes, and failures during the entire period of supervision. The supervisor evaluates the trainee's performance and progress; the trainee evaluates the supervisor's helpfulness, methods of supervision, and in general what the placement, in his estimation, has taught him and has contributed to his professional growth.

Each evaluation by supervisor and trainee should be written, shared, and signed by both before the trainee leaves the placement. The evaluation should take the form of a narrative, observing and commenting on a number of areas. Among these will be the supervisor-trainee relationship; relationships between the trainee and his peers, relationships with patients, staff, and patients' families; ability to function as a member of a multidisciplinary team; handling of stressful situations; translation of new insights and knowledge into behavior; theological and psychological orientation; competence in dealing with theological issues; maturity of professional self-concept and ability to live it day by day; maturity of self-insight and inner dynamics; problem areas and the progress made with regard to them; and suggestions for the future, both for the trainee, the supervisor, the placement, and the program.

The evaluation should not be a mere rating of the trainee's and the supervisor's performance, but should contain suggestions for

the future of all involved in the program. In particular, the student's evaluation of himself ought to include some theological reflection and assessment of his experience and its contribution to his professional growth.

* * *

Any supervised hospital ministry should include both a didactic program and monitored patient and staff contacts. The didactic program should be comprised of orientation lectures by and discussions with key hospital personnel, i.e., the hospital administrator, the chief of staff, and the heads of various services or designated members of their staffs.

Ideally, the placement experience ought first to consist of a more general orientation to hospital ministry, and then later, opportunity to gain deeper experience in one or two of the more specialized programs, such as open heart surgery, hemodialysis, cancer chemotherapy, alcohol and drug abuse, psychiatry, mental hygiene clinic, etc.

Supervision seminars, in addition to the individual supervisory conferences described above, should cover such topics as Death and Dying, What It Means to a Person to be Sick and Hospitalized, Multi-disciplinary Patient Care, Morality of Accelerating Death for Terminal Patients, and other controversial or timely issues.

Each trainee should be assigned to an experienced chaplain for supervision, with no more than three trainees per chaplain. Patient contacts should be arranged for each trainee through his assigned chaplain and the nurse in charge of the unit on which the patient is located.

Trainees should have access to the general medical library as well as a more specialized library maintained for educational purposes by the chaplain service. The latter ought to contain most of the classical literature on pastoral care, pastoral counseling, and especially hospital ministry, as well as all of the most recent literature in these fields.

A minimum of six hours per week should be required of each trainee. Agreement to spend this amount of time in the hospital should be included in the contract drawn up by supervisor and trainee in the initial interview. Any program which involves less than this will not be sufficient to afford enough experience; any which exceeds it greatly will take too much time from the trainee's other academic obligations and commitments.

Chapter Fourteen

PHYSICAL HEALTH OF THE CHAPLAIN

James J. Bergin, M.D.

Traditionally, a priest was given a hospital post because of advanced age or illness. In essence, the assignment represented a comfortable transition toward retirement. The justification for this approach was the supposedly sheltered life and the ready availability of medical care. However, the hospital's new environment and language, its constant crisis orientation and its compelling focus on physical disability create quite the opposite environment. The hospital chaplaincy is a mentally and physically demanding vocation. The hours are long, miles are walked, sleep is interrupted. It is essential that consideration be given to the physical health of the chaplain if he is to pursue successfully this important ministry.

Consider the training of a physician. He is gradually nurtured through his student years, internship, and specialty training so that he can successfully accept increased responsibility. By design, his exposure to medical crises is graduated. With the assistance of peers and supervisors, he is guided through these difficult years so that he can recognize and deal with his own anxieties and physical health. By contrast, the priest, having little or no previous medical experience and knowledge, is propelled into a strange and challenging environment. This sudden exposure places the priest in a direct confrontation with his own humanity. Underlying anxieties quickly surface and may masquerade as physical illnesses. Ignorance of elementary health measures can cause serious problems.

Reasonable flexibility in work, study and relaxation decreases tension and is less physically taxing. Duties fall into categories, such as administering sacraments, visiting patients, and family

counseling. Although one's day may be planned in an orderly manner, interruptions are unavoidable and the schedule should be appropriately constructed to accommodate these exigencies.

Like the physician, the priest must be committed to intellectual advancement. Reading current literature and attending workshops and conferences should be part of the monthly plan. The chaplain improves his effectiveness by such activities. Recreation complements work and study. It is best carried out daily. The younger the priest, the more physical the endeavor may be. Jogging, handball, and tennis are excellent examples of physical activities which require little rearrangement of the day. No matter what a man's age or physical condition, a brisk walk outside the hospital is always conveniently available. Although it is difficult to prove convincingly that regular exercise prevents or delays many types of degenerative disease, all who follow this course report an increased feeling of well being. Once a week the chaplain should be free of all duties in order to enjoy life outside the hospital setting.

An approachable, respected, relatively senior staff physician can become an important friend. Of course, the relationship must be equally relaxing and enjoyable. The priest should learn to appreciate not only the doctor but also his family. There is a common bond with much to be shared. A few moments of conversation can clarify many issues. Hospital procedural matters, feedback from pastoral activities, questions regarding basic anatomy and physiology are easily understood through discussion. The chaplain is likely to become perplexed and distraught if he fights imagined enemies in loneliness. There is no substitute for comfortable dialogue between medical team members.

Among general health habits, diet and eating are of great importance. The physician, early in his professional life, finds that irregular eating habits are easily acquired: there is always another patient to be seen. However, short-term gain is cancelled by inevitable ineffectiveness. In our society, man performs best with three well-spaced meals, and time must be alloted for them. Caloric intake, well-balanced, should be adjusted to physical needs. Mental stress is often mollified by oral gratification. However, few calories are needed for intellectual processes. The cycle of overwork, anxiety, and excessive eating leads to obesity. Overweight

invites the risk of heart attack, diabetes, hypertension, and increased surgical mortality, to name a few of the problems. Thus, regular eating habits and maintenance of an appropriate weight are essential to health and perhaps also to continuing professional competence. The obese priest, although often portrayed as loving and kind, is hardly an example of health to staff or patients.

The vast accumulation of medical data has incriminated cigarette smoking as deleterious to health. The patient with lung cancer or emphysema, who is fighting for each breath, is appalled when he sees his health team members indulging in the indiscretion which led to his own illness. If the priest wishes to pursue smoking which he knows to be injurious, he should at least avoid smoking in all situations of patient contact.

Much has been said and written about excessive use of alcohol. Aside from the moral issue, the impact of immoderate drinking on health is recognized. Hospital wards contain many patients with cirrhosis of the liver, delirium tremens, and other alcohol-related illnesses. The priest who spends an excessive amount of time by himself is especially susceptible to the problem of alcohol abuse. Just as important is the effect of alcohol on continuing performance. Even though an individual has not been drinking during the day, his judgment can still be impaired from a previous night's excesses.

The problem of drugs is more insidious. The chaplain encounters many physicians sympathetic to his difficult ministry. A prescription for medication can be readily obtained. Overwork and tension may lead to insomnia. A few sleeping pills may correct this problem. Conversely, an energizer may permit longer working hours. In either case, a tranquilizer may also be added. The process may start with a few pills here and there, but prolonged and increased enough lead to habituation or addiction. This problem can be found in the entire medical team and is best handled by having an individual receive all medication from one doctor and one doctor only.

The chaplain should be required to have an annual physical examination. Chest x-ray, blood count, blood chemistries, and urinalysis are routinely obtained. Other testing may also be required on the advice of a physician. It is amazing how many seemingly difficult problems are easily solved by appropriate dental care

or corrective glasses. To cite an example, every physician has hidden symptoms which he suspects reflect a fatal disease. Objective evaluation usually reveals a minor illness. Faced with daily medical crises and inadequate medical knowledge, the chaplain's position is even more precarious. If he is reflective, he will admit that he often unnecessarily worries about real or apparent symptoms. He may unconsciously resist and delay investigation. In this setting, an annual assessment of the chaplain's health should be mandatory.

Urologic problems seem to be a special threat to the Catholic priest. Enlargement of the prostate gland partially obstructs the flow of urine and may be reflected in urgency and frequency of urination and in awakening to void at night. Inflammation of the prostate, not uncommon in celibates, may cause a urethral discharge and painful urination. These common complaints can cause a variety of unresolved guilt reactions and fantasies to surface, resulting in neurotic behavior and severely compromising effective ministry. Medical attention to the problem is the essential step toward physical and mental health.

The hospital chaplain's awareness of his bodily processes should encourage him to employ measures to ensure his continued good health. He is well-advised to seek one physician to care for all his medical problems. He should have a very open and honest relationship with his physician and feel free to discuss and not to bury his anxieties.

In conclusion, a hospital chaplain is placed in a mentally and physically demanding situation. His daily work forces him into direct confrontation with his humanity. Observance of the general and specific health measures discussed here will help maintain the chaplain as a physically and mentally sound and valuable member of the medical team.

Chapter Fifteen
SOUND MENTAL HEALTH PRACTICES IN THE CHAPLAINCY

Benedict J. Groeschel, O.F.M., Cap., Ed.D.

Many aspects of service to the physically or emotionally ill in health care facilities tax mental health. Most professionals in the health care field find their days filled with demanding schedules, requests for immediate services, emergencies and constant involvement in the emotionally draining crises of the sick and dying.

The involved chaplain shares in full measure in the emotional burdens of hospital life. Daily he must help patients, their families, and even the staff to live out their roles in the drama of sickness, recovery and death, which is the life of a hospital. Mental health chaplains and those who serve institutions for the chronically ill, while their work is not as dramatic as that of general health care chaplains, must be constantly encouraging to those who may be hopeless or are at least depressed by their situation.

Even though a chaplain has personal resources of faith in God and draws strength from the teachings of the Gospel, he must take care of his own mental health and adjustment. He owes this to himself, to the patients, and to the staff. A priest operating under excessive mental strain is never able to give his best to his work.

Unfortunately, how to plan a good program for mental health is a mystery to most people. While many people evidence concern for their physical health by programs as diverse as dieting and jogging, few ever stop to ask whether they are protecting their mental health. We tend to take mental health for granted, accepting it gratefully and perhaps fearing its loss, as if it were the result of some magic over which we have no control. The fact is that, with the exception of persons suffering from serious chronic mental

illness, anyone can do much to preserve and increase the quality of his mental functioning. This process is called adjustment.

No human being lives in a perfect environment free from problems and challenges. No one's natural endowments are entirely adequate to his particular situation. Each of us is a combination of strengths and limitations which, in the process of living, we have fashioned into a tool for coping creatively with reality. We call this tool personality.

In the development of personality we encounter some situations more or less beneficial and others more or less destructive. Ordinarily we profit from the former; but we can also learn from the latter if we are motivated to do so. The strength of motivation can be immensely increased by grace as well as by a consistent Christian philosophy of life.

But that is not enough. It has been said so often that grace builds on nature that the statement's meaning is somewhat lost on us. As far as mental health is concerned, it means that it is particularly important to preserve the best possible adaptive psychological structure so that grace can operate.

What are the ingredients of a good mental health program for a chaplain? They do not differ essentially from the needs of other persons. But they must be discussed in the unique context of the chaplaincy. The ingredients include: 1) a creative work environment; 2) reasonable re-creation or recharging of energies, including good community life and /or meaningful personal relationships and "recreation" properly so called; 3) opportunities for psychological and spiritual assistance in times of difficulty and strain; 4) a mature and integrated spiritual life.

A Creative Work Environment

A good working or vocational environment is essential. Often it is attitude rather than external circumstance which determines the psychological impact of a job situation. One person may approach a good job situation with a negative and defeatest attitude and suffer through years of depression. Another may approach a difficult and apparently frustrating position with a creative attitude and make it a meaningful experience for himself and others. An objectively difficult situation (such as a hospital where a former chaplain fell below expectations and created an atmosphere of hostility)

can often be improved by a positive and tactful approach. We often tend to be drawn into negative relationships without noticing it, without stepping back from the situation long enough to analyze objectively the components of the problem. It is far better to try to objectify a problem and to adjust what can be changed than to adopt an attitude of passive endurance of unnecessary pain.

At times the components of a particular job situation are simply beyond a person's coping ability. It is best to recognize such a situation before it wears down one's psychological resistance and to take effective means for a change while the situation is still relatively stable. Often we fail to talk things out. We wait until we have to blurt out our hurt feelings in a defensive way. A person who thinks it a virtue to suffer with an unnecessarily difficult situation which can be changed is acting foolishly. One who invests his energy in making a situation work as effectively as possible, with a minimum of psychic wear and tear, is doing what needs to be done to be a creative human being and a pastor of souls.

Re-Creation

The human body, including the central nervous system which is the mechanism of psychological functioning, operates on electrochemical energy. Like any such system it must be constantly cared for lest it "burn out." The psyche is an even more complex entity which is subject to many stresses and strains. Every day the body and the mind need to be refreshed.

The most effective form of psychic recreation is the exchange of ideas and feelings with those whom we know and trust. For the married, this exchange of relationships is found mainly in the family; for those in religious communities it is found in the religious family. But the chaplain, whether a religious or diocesan priest, often finds himself alone. It is imperative that most individuals living in this situation develop friendships and re-creative relationships consistent with their vocation.

It is unwise and even unkind to think that this need can be totally fulfilled by our inter-personal relationships on the job. We should not impose our needs on those who have a right to look to us for fulfillment of their needs. Since different people have different needs and different ways of fulfilling them, it is impossible to be more specific in a general treatment such as this. But every chap-

lain owes it to himself to take stock of his need for friends and emotional support. If he lacks appropriate friends and opportunities for friendship, he should ask himself how he can improve his lifestyle.

More obvious forms of re-creation include a sensible work schedule, with regular meals and sleep. The needs of people vary immensely, but everyone must follow a schedule adapted to his needs to survive without stress. A chaplain usually is "on duty" in some sense whenever he is in the agency or institution. He must therefore build into his schedule periods when his responsibilities are handled by someone else. The number and duration of these periods may vary from individual to individual, but every chaplain needs times when he is definitely *not* "on call." A conscientious chaplain never refuses a call; therefore, if he is to have periods of true relaxation, he must schedule times when he *cannot* be called.

Psychological Assistance

Into every life a little psychological rain must fall. No one, no matter how "normal" and well-adjusted, can help but start to fail in his life adjustment if subjected to enough stress. At times of stress caused by work, or change, or any other factor, a person may need to turn to someone for help and clarification of his ideas and goals.

A priest often feels that he is above such things—that it is a sign of weakness to seek aid or support. Or perhaps he feels that if he is completely preoccupied with the needs of others, his problems will go away. This is a "magical" attitude toward mental health. The life of the chaplain has its own particular stresses and it is wise to be sensitive to the indirect cues by which others may tell us that we need a psychological tune-up. Often a good chat with a spiritual director or friend is sufficient. But it can be a mature acceptance of reality to seek professoinal counseling and assistance if this is indicated.

In some professional and social groups psychotherapy is an addiction. This is not usually the case with clergymen, and it is a very rare addiction indeed among Catholic chaplains. The chances are that if it occurs to a chaplain that he may need professional help, he does.

Spiritual Maturity and Integration

Personality adjustment has often been confused with spiritual maturity. This confusion has caused many clergymen and religious either to ignore the dynamics of spiritual maturity or to focus entirely on religious concerns while rejecting psychological insight as esoteric. The fact is that, although the spiritual foundations of Christianity need no psychological defense, an active spiritual life is psychologically essential to the person who desires to be a truly integrated Christian. A mature and integrated Christian both values the Christian faith and has the strength to live it.

Every chaplain, in order to be an integrated person, must desire to serve Christ in the person of the sick and needy. If he has this goal but fails to live an active spiritual life, he will engender in himself a profound and devastating conflict. He may survive, but his life will lack direction, joy and peace. He will experience the bitter frustration of trying to help others love and serve a God whom he scarcely knows himself.

Living the spiritual life both requires and confers the peace which the world cannot give. This peace, the fruit of faith and love, cannot be found by a person who never stops to examine his own soul. A chaplain who begins the day with quiet recollection and stops occasionally during the day to find his Master in the depths of his soul will be a happier and more effective man.

Some chaplains excuse the superficiality of their spiritual lives with the bromide that their work is their prayer. Work done in obedience and openness to the needs of others is indeed a prayer; but no prayer is possible or real in a heart empty of God. Unlike many priests, the chaplain can usually make his own schedule, consistent with the heavy demands upon him. He owes it to himself to build into his schedule times for recollection, prayer and quiet meditation, as well as time for the reverent and meaningful functions of public liturgy. The sick, the poor and the needy look to us to bring God to them. We cannot do this if we have lost track of ourselves or of God who dwells within us.

Chapter Sixteen

MEDICAL ETHICS IN A CATHOLIC PERSPECTIVE: SOME PRESENT-DAY TRENDS

Warren T. Reich

This chapter will be in four parts. The first part will describe the tasks of medical ethics, particularly as they affect the chaplain. Some observations on natural law and scripture in the second part will serve to introduce certain elements of renewal in medical ethics. The third part will set forth some of the problems involved in medical ethics as taught by the magisterium. Part four will deal more specifically with some principles of medical ethics and some cases which point up the current differences of opinion on medical ethics as pursued in a Catholic context.

I. Requirements of Medical Ethics Today

Partially because the chaplain is called upon to fill a great variety of roles besides that of moral counselor in the contemporary health care facility, it has become a widely accepted dictum that he cannot supply pre-determined answers to a whole host of questions in the field of medical ethics.

His limitations in medical ethics, however, are not dictated solely by the demands of his vocation to pastoral service. The very stuff of which medical ethics is made is constantly developing. Very little remains static in the life sciences, for medical progress is constantly raising new questions and altering the terms of the old questions. Furthermore, medical ethics itself continues to develop its own methodologies according to the questions that are being asked.

In this situation a contemporary presentation of medical ethics may be as adequate as its authors are capable of producing, but it will always leave something to be desired. The medical professions and health care institutions issue codes of ethics which are usually statements of some principles and of what is minimally required for purposes of declaring, preserving and sometimes enforcing certain standards of behavior which uphold the goals and objectives of these professions and institutions. But these codes leave many important questions untouched; and although they focus on good and acceptable behavior within the professions, they offer very little guidance in many of the more difficult areas of good ethical decision-making.

In the Catholic Church in this country, those who hold the position of official teachers of religious and ethical doctrine have, in recent years, turned their attention to medical ethics and have issued (in 1971) a set of *Ethical and Religious Directives for Catholic Health Facilities*. These directives have become official policy for most Catholic health facilities, and they propose some important standards for good medical ethics. They contain some specific prohibitions which probably ought to be further revised; and the directives have been criticized for not striking a good balance between the presentation of institutional policy on the one hand and, on the other hand, the need to admit certain ambiguities which necessarily arise in the context of pluralism and legitimate freedom of conscience. Yet even the most adequate set of directives arrived at by common agreement will fail in filling all the needs of the moment.

There will usually be a considerable time lag between a medical advance and a mature evaluation of its ethical implications. An example can be found in the Catholic Church's teaching on organic transplantation from one living person to another. In the 1950s, initial reactions from the pope and from the theologians who most closely followed him in their writings were quite skeptical, leading at first to a common opinion opposed to this action; yet today there is scarcely anyone who would deny the licitness and even the heroic virtue involved in such a procedure. What should be noted is that most of the initial progress in transplants was accomplished before this favorable theological consensus existed within the Church.

Nonetheless, neither the ethical spokesmen for the Church nor those within the medical profession can completely avoid the "embarrassment" of this time lag, for one is not always prepared philosophically and theologically to react both swiftly and maturely to new biomedical advances. This state of affairs creates certain exigencies which affect the medical ethics of health care facilities and in particular the role of Catholic chaplains in medical ethics. Specifically, it involves three implications pertaining to personal study, methods of decision-making, and the development of a personal ethic.

First, it is more apparent than ever before that it is essential to be well informed on newer developments in the principles and methods of medical ethics, as well as in the varieties of opinions offered on a particular problem area such as definition of death, informing the dying, human experimentation, genetic counseling, and the like. Every chaplain knows the experience of not having the full answer at hand and having to rely very much on his own study, reflection and insight to assist others in their attempts to make responsible decisions.

Second, because the medical situation is always changing rapidly and the ethical responses are in many cases tentative, the art of ethical decision-making becomes important. It is essential that we become sensitive to the contingencies and variables involved in the ethics of medicine. To arrive at a reasonable solution for many questions, good ethics focuses very much on weighing the beneficial against the imperfect. For example, when not all the desirable goals can be achieved in a marriage without some conflict of values, what measures ought to be taken to control the powers of reproduction? The questions of contraception, sterilization, fertility testing and treatment of infertility are very complex, involving many deeply felt human values and aspirations. Only one who is sensitive to these values in their human context and to the requirements of personal responsibility will be prepared to cope adequately with the problems of ethical decision-making—and the chaplain is frequently in a unique position to facilitate wise decisions.

Third, the present situation calls for the development of a refined personal ethic on the part of those dealing with the ethics of life and death. Even firm and unambiguous codes of ethics, or

ethical directives such as those currently approved for most U.S. Catholic health facilities, can neither guarantee nor take the place of "the ethical physician," "the ethical nurse," "the ethical administrator," and so on. The goal of medical ethics is not the development of a policy which can be admired, but rather the enhancement of real, effective goodness on the personal and social level. Ultimately, it will depend on the individual decision-maker and his own ethical values as to whether this will actually be achieved, especially in a period when the theoretical ethics on many topics develops slowly and offers differing opinions. The chaplain, through his pastoral service and his own religious and moral formation, can be a powerful agent in assisting the development of a personal ethic on the part of the professionals and patients involved.

II. Natural Law and Scripture

There is a great deal of controversy today over many issues in medical ethics. Most of the normative principles which come to us in traditional Catholic medical ethics have been conclusions drawn from a natural law theory, or from "the law of reason." This method has been an attempt to know the will of God through his work in human nature, so that a corresponding conformity to the "law of nature" might assure conformity to the will of God. Prime examples of this have been in the area of sexual ethics, where respect for the "purposes of nature" has led to the absolute prohibition of certain acts which frustrate the natural (in the sense of physical) purpose of the act, such as contraception and sterilization.

The natural law tradition has provided a solid basis and firm norms in a longstanding tradition of medical ethics. But in the past 15 years or so, serious questions have been raised about many of the presuppositions and conclusions of the dominant natural law methodology. For the most part, theologians and other ethicists have not concluded that the natural law approach should be rejected, but that it be reformed so as to incorporate other truths about human nature and man's relationship to God. A re-thinking of natural law ethics has been stimulated especially by newer insights gained from scriptural studies. An examination of the relationship between natural law ethics and biblical ethics should be of assistance in understanding the elements of Christian

ethical decision-making in the area of medical ethics. Some leading theologians in the 1950s and Vatican II in the 1960s called for a renewal of moral theology based on the Scriptures. The attempts to base morality on the word of God are well known, and have resulted in a renewal of religious education. While scripture has immeasurably expanded our ethical vision of man, its use has also pointed out that the answers we have relied upon in natural law teachings are not always so adequate and incontrovertible as we may have thought.

For example, while the natural law teachings have been based predominantly on the notion of man as created, the New Testament places a great deal of emphasis on man as redeemed. The law of grace enjoys a certain primacy in man's pursuit of the ethical. God's call to man and man's personal response in grace are more than beautiful truths: they can and do create their own imperative which cannot be adequately expressed in any ethical norm elaborated by Church or society.

A set of norms is needed to remind us of our sinfulness and weaknesses and to assist in the educational process of forming a social moral force against sin in the world. For instance, unless a social group (whether a church or a secular group in society) subscribed to a norm in defense of innocent human life, there might not be the social solidarity and moral pressure needed to withstand the selfish anti-life forces in the world. Yet it would be mistaken to believe that the Bible systematically proposes concrete norms all of which are valid for all times and can answer the medical dilemmas of today and tomorrow.

The New Testament does not present a systematic normative ethic as a fundamental guide to Christian living, but a religious message of salvation—and that message is that the kingdom of God is at hand and that the merciful God offers love and salvation in his son Jesus Christ. Christ was not one whose task was to perfect the moral laws as such; rather, he invited all men to subject themselves, their lives, their actions and their ethical norms to the one law of love which was his first and greatest command. Nonetheless, the ethics of Jesus did find expression—especially in the apostolic preaching—in concrete ethical demands, such as the need to avoid gross indecency, gluttony, and improper use of potions. The norms were historically and culturally conditioned.

The New Testament writings did not create a new system of ethics nor did they set out to change social conditions and institutions (male dominance, oppression of the laboring class, marriage). Instead, the preaching of the early Church attempted to subject to the radical demand of love the historically conditioned cultural and religious norms which were known at that time. In this way, it was possible for the New Testament preachers to take a stand on which concrete demands should be made of Christians in their historical milieu by their life of faith and love. All directives and admonitions were considered an application of the more basic and unchanging law of love to the life of those times.

Consequently, some scriptural norms "withstand the test of time" and some do not. A universal and lasting norm is the moral demand that the relationship of spouses should perfect itself in love, and that the consequence of true love is an unconditioned bond of fidelity. In this respect, what was judged good behavior for the first Christians also has an abiding importance for our age, according to the radical demands of love. A more culturally conditioned norm which has not withstood the radical demands of love is St. Paul's directive that the wife be subservient to the husband.

If the natural law medical ethics of today is to be Christian, it must be subject to the same methodology. It must enter into the unceasing process of subjecting various medical procedures, health care measures, research efforts, and our present-day ethical standards to the radical demands of love. New Testament models for Christian behavior may shed some light on the contemporary question, but on the other hand they may leave most of the search for ethical norms to the Church of today which is living in the midst of various societal value systems. The individual in his own moral life and the Church in a more corporate way will be able to take a moral position on the issues of life and death even if some of the norms have to be formulated in a somewhat tentative fashion.

An example of the impact of this "biblical methodology" on modern medical ethics can be seen in the Catholic Church's judgment on organ transplantation, particularly after kidney transplantation became feasible in 1954. After the procedure was frowned upon by Pius XII in the 1950s, apparently because its

justification through the principle of totality (the only relevant principle Pius seemed to be aware of at that time) might open the door to the manipulation of people and their parts for national and social purposes, many theologians justified transplantation *inter vivos* by subjecting the concept to the demands of love. They concluded that it was a licit and even praiseworthy action because it was an expression of those bonds of love between donor and recipient which incline the donor to do for others what he would want done for himself.

Many contemporary problems in medical ethics find little explicit clarification in Scripture. Organ transplantation was unknown in those times and behavior modification could not be manipulated as today. Scripture teaches the sacredness of human life but gives little help for the practical decisions about the use of "extraordinary means" for preserving life. However, an ethic for the newer problems is not completely lacking: it is to be found among the works of contemporary philosophy and theology, in the scientific literature, and in the pastoral reflection on the impact of certain kinds of behavior on Christian life today. A scripturally inspired medical ethics would turn to contemporary wisdom of any sort, subject it to the radical demands of love in the light of similar scrutinies in the Church's past, and then courageously propose a type of behavior which will serve as an ethical orientation for our times.

This methodology is not just one to be pursued by the theologian in a theoretical way, but also by pastoral persons in concrete cases. Without in any way belittling the process by which we arrive at legitimate moral norms, it can be said that a courageous scrutiny of difficult problems in medical ethics under the clarifying light of the demands of love can also give us an awareness of values and violations of values and an indication of preferred courses of action in such areas as the right to informed consent, the primacy of the good of the patient over the preferences of the physician, the dignity of the retarded, and so forth.

III. Medical Ethics and the Magisterium

The Church does not rely solely on Scripture and contemporary ethics for its understanding of the ethics of medicine and the life sciences. The Catholic Church also relies in a special way, though not exclusively, on its officially designated teachers and

their magisterium, or teaching office. The largest bulk of papal teaching on medical ethics was issued by Pius XII, who spoke on such widely scattered topics as organ transplants, prolongation of life, lobotomy, artificial insemination, abortion, natural childbirth, and the shortening of life through use of drugs.

It should be noted, however, that there is a legitimate development of ethical doctrine within the Church. For example, teachings on the morality of war have varied greatly; papal teaching on usury has been abandoned; and 19th century papal utterances on religious liberty could hardly be reconciled with the statements of Vatican II on the same topic. The ethical teaching of the Church's magisterium is historically and culturally conditioned, though in some instances the truth of its teachings obviously withstands cultural revolutions and historical developments. Certainly it would be a mistake to accept a doctrinal assertion as unalterably true simply because it appears to be traditional and has been taught by the hierarchy.

Catholic teachings in medical ethics are particularly subject to change because of the limitations of the competence of the Church in giving a definitive ethical word on matters scientific. Thus, changes have occurred in "Catholic thought" as theologians have become better informed medically. But the development of Church teaching is also served by new theological insight, for hierarchical teaching is always dependent on theology for a religious and moral interpretation of the modern world and its problems.

A "traditional" magisterial teaching may not be a definitive teaching and usually is not binding in an absolute way. The papal teaching opposed to direct sterilization, for example, has a relatively short history; it has been less forcefully taught in the past as compared with papal condemnations of contraception; and it is more highly qualified nowadays by traditional moral theologians so as to permit sterilization in more instances (after childbirth, in danger of rape, in cases of psychiatric disorder, etc.).

The obvious development in the Church's understanding of the ethics of many medico-moral procedures helps in understanding why the formal binding power of normative ecclesiastical statements is something less than infallible. They should be taken seriously due to the seriousness of the question and because of

the importance of these teaching functions within the Church. But it should also be acknowledged that these norms always carry with them a characteristic of tentativeness—a certain provisional quality which means that they are neither absolutely certain nor arbitrary and unimportant. They are assertions by a Church teaching authority which knows it ought not be silent in the face of an important issue, and yet knows it cannot give the final word. It is a religiously motivated assertion of a moral insight "according to the best lights" of the magisterial authority.

The teachings of the official magisterium on questions of medical ethics will never achieve their purpose unless they are set in dialogue with other persons and groups within the Church and within society, such as medical and hospital personnel. To claim for these teachings the full force of law or the compelling finality of a revelational-doctrinal assertion is to block their reinterpretation, stultify their moral application, and conceal their real ethical value. It is important to regard the Church as an open "system" in which many diverse factors work together both for the clarification of our faith-consciousness and for the development of principles and norms for our moral life.

In the past it was often said that debated questions in the field of medical ethics were settled and no alternative options were realistically available if statements of a pope, particularly the decrees and allocutions of Pius XII, were found to take an explicit stand on the issues. Since the issuance of *Humanae Vitae,* however, the hierarchical statements of many national episcopal conferences and studies conducted by Catholic theologians have made it clearer than ever before that a position of dissent from non-infallible papal teachings is legitimate under the following conditions: (1) that the one who dissents have competence or experience in the topic under consideration (but this should not be interpreted to mean that dissent is only possible for the elite); (2) that he have good reasons arrived at after serious study and reflection; (3) that he continue his investigation and not consider his opinion in any sense definitive; (4) that he retain his respect for the teaching authority of the Church and give full religious respect to the "authoritative" teaching of the hierarchy; (5) that no undue harm be done to the life, well-being or rights of a third party; and (6) that he take whatever steps are needed to avoid scandal—which is not the same as avoiding anything that causes surprise or

amazement on the part of others, but rather means that precautions be taken to prevent this exception from causing more harm than good, so as not to hinder significantly the moral welfare of others.

The clarification of the right to dissent in recent years helps to establish a new atmosphere for the pursuit of medical ethics, for we now acknowledge more honestly that the analyses and conclusions of yesterday are not necessarily true in every instance and for all times. But the counselor, advisor, or teacher should be aware that in many ways making explicit the right to dissent in good conscience only opens the door to a host of new questions. Irresponsible dissent can roll back the force of human values which required centuries to develop, such as a respect for the sacredness of human reproduction. Dissent-with-ease can encourage professional and institutional abuses, such as sterilization of "undesirables." Those who know of the right and responsibility to judge the applicability of a directive in medical ethics may easily overlook one or the other criterion for legitimate dissent; thus the need to avoid undue harm to the life, well-being or rights of a third party might be neglected in an abortion case.

There is need for a more thorough education concerning the limits of dissent, so as to avoid or at least minimize abuses. But abuses in making exceptions to the norm do not remove the right and the responsibility enjoyed by patient and physician to make conscientious judgments, just as abuses in the enforcement of norms do not remove the need for official institutional policies. The need to strike a balance between these two claims is probably the major problem in the medical ethics of health care institutions today. Much more consultation, dialogue, study and reflection are required to advance knowledge and promote wisdom in this area.

IV. Towards the Total Good of the Person

The "natural law" upon which Catholic medical ethics has relied is not so much a body of principles and norms about human nature as it is simply a moral methodology for understanding man and his moral life. The natural law methodology has been subjected to some uncritical uses. For example, to assume without further ado that what corresponds to the physical and biological "laws of nature" is also required by the *moral* laws of nature

results from a narrow view of human nature which is too exclusively preoccupied with the physical. This view of human nature is erroneous because it fails to give sufficient importance to the moral law as a law of reason. It is only through the use of reason that man can discover which goals in life are the preferred ones, which values are to be given precedence, and which actions are going to be judged contrary to the good of man.

Man's reason makes it apparent that man is more than physical parts, physical faculties and physical acts: human nature is the entire person—physical, psychological, spiritual and social. In fact, this is the major trend in natural law thinking today: the trend away from the isolated act analysis which is also a trend toward judging morality in terms of the total person and the total good of the person.

It can be quite misleading to categorize acts as right or wrong in the abstract simply in terms of how they are physically describable. We are speaking of the negative moral absolutes ("thou shalt not . . . "), which are principles according to which a specific external action, defined in physical, non-moral terms, may never be used as a means, no matter what the circumstances or end in view. The implication is that there are certain acts which, if used as a means even to a good end, are always immoral. The problem is whether it is really true that a specific external action, defined in physical, non-moral terms, can never be used as a means no matter what the circumstances and the end in view.

An example would be the act of killing, or more precisely the direct killing of an innocent person. The act of shooting a person cannot be called morally wrong unless some moral circumstance is added. If done as an unjustifiable act of aggression it is an illicit act of violence; whereas if done in self-defense it would be licit and even virtuous.

The ethical quality of the act should not be judged simply on the basis of its physical description, but also as informed by a certain motive. Theologians are more inclined now than in the past to give weight to the motive or intention as an important and sometimes determining element of morality.

The move away from the isolated act—isolated both in terms of physical description and intentionality—is also seen in the

trend to judge actions in terms of their effects or consequences. A mere consequentialism should be avoided, if by this we mean that one does not know whether an individual act is good or bad until it is completed and one measures the good that has been accomplished or the harm that has been done.

But there is also a traditional and more valid consequentialism, which groups together acts of a certain kind and, in light of the ethical and specifically Christian values involved in the total moral context, judges their ethical quality from consequences. For instance, the predominant explanation given for the traditional disapproval of non-marital sexual intercourse has been that of St. Thomas Aquinas which was based on consequences. The non-marital sexual union is transitory, and because it lacks a permanent bond, of its very nature would deprive the children who might be born of such a union of the proper conditions for their upbringing. Thus, the harmful *effects* of "fornication" on the "education" of possible offspring is the determining moral reason.

A consequentialism must necessarily be employed in judging the morality of some of the newer, relatively uncharted options that are or soon will be before us. For instance, we do not yet know how *in vitro* human fertilization or sexual human reproduction will affect the values of family life, nor do we know the full significance of the love of natural parents for the child. According to some, there already exist good reasons for excluding these procedures; but it would seem that a moral judgment on them would be more solidly based and more reasonable if more were known of their effects. At the very least, this example shows that the natural law cannot be considered a pre-determined set of moral principles known *a priori*. A law of reason, especially if it is to establish reasonable *a priori* norms, must rely more on the *a posteriori* experience of human behavior.

A more common case can be given as an example of the need for rethinking our ethics in view of the total moral situation, including the consequences. The *Ethical and Religious Directives for Catholic Health Facilities* (1971) states in par. 16:

> In extrauterine pregnancy the dangerously affected part of the mother (e.g., cervix, ovary, or fallopian tube) may be removed, even though fetal death is foreseen, provided that:

(a) the affected part is presumed already to be so damaged and dangerously affected as to warrant its removal, and that

(b) the operation is not just a separation of the embryo or fetus from its site within the part (which would be a direct abortion from a uterine appendage), and that

(c) the operation cannot be postponed without notably increasing the danger to the mother.

Thus, the organ or part where the pregnancy is located may be removed even when this involves the death of the fetus, but the fetus itself may not be removed in such a way as to leave the reproductive organs undamaged. When one considers that the Catholic ethical system has forcefully sustained the obligation of openness to new life, it is rather paradoxical that of two cases involving the death of the fetus the sterilizing procedure is approved, whereas the one which retains the possibility of future children is rejected. Theologians today would particularly criticize the exaggerated distinction between "direct" and "indirect" involved in the *Directives'* solution. It should be noted how the above cited paragraph focuses moral intentionality on the correction (removal) of the "dangerously affected part" and makes the more consequential danger (to the mother) seem rather secondary.

The trend in contemporary medical ethics is clearly toward seeing the total good of the person as the overriding ethical criterion. Thus, the principle of totality, in contemporary moral literature, is not so exclusively defined in terms of seeking the good of the physical totality of man, but directs our moral concern toward the total good of the total man—physical, psychological, spiritual and social.

If this more total view of man were an acknowledged part of official Catholic ethical directives, the total fertility of the woman cited above might have been accorded a higher priority. So too, cases in which a woman cannot sustain future pregnancies should be judged in terms of the woman's total effective fertility (which has ceased, since viable life is not possible) and in terms of her total welfare (which would indicate that a responsible recourse to

sterilization might well be extended beyond the present limits imposed by the current official interpretation of the meanings of direct and indirect sterilization).

CONCLUSION

Moral theologians are not always in agreement on matters in medical ethics that seemed quite settled less than a generation ago. As this chapter has tried to indicate, the reasons for today's pluralism of thought within the Catholic Church are found at the very roots of ethics—how it is affected by Scripture, how it is qualified by the magisterium, and how it is given new directions by contemporary views of the meaning of man. While a review of this kind may not solve many specific problems, a deeper understanding of these developments of thought in medical ethics should be a good preparation for facilitating and assisting responsible ethical decision-making in today's world of medicine and health care.

Chapter Seventeen
THE HANDICAPPED— HELPING THEM IN THEIR SUFFERING

Thomas F. Cribbin

The following are summary practical notes from the panel that presented the information to the chaplains both in 1972 and 1973 at the Pastoral Institute for General Hospital Chaplains held in Washington, D.C. The panel is comprised of members from Catholic Charities of the Diocese of Brooklyn Office for the Handicapped. That office services all of the handicapped. Under one administration, various programs are sponsored to care for the spiritual, temporal, social, recreational, educational, and pastoral needs of the handicapped of the Diocese of Brooklyn. These include the deaf and hard of hearing, the blind and visually handicapped, the mentally retarded, and the physically handicapped.

These notes are the work of the panel which included Reverend Thomas F. Cribbin, Director of the Office for the Handicapped, Sister Bernadette Downes, C.I.J., Coordinator of Programs for the Office for the Handicapped, Brother Joseph Moloney, O.S.F., Director of the Training For Life Team for the mentally retarded, and Mr. Frank Hall, Program Manager for the mentally retarded and leader of Team 2 which is responsible for all pastoral programs in the Office for the Handicapped.

The Deaf and Hard of Hearing Patients

1. Deafness is intended to include people who have no useable hearing. They may or may not have understandable speech. The hard of hearing are those individuals who have some loss of hearing, but

with the use of a hearing aid, can function in a normal hearing world.

2. In dealing with the hearing handicapped, speak simply, never use big words. Remember the average deaf person reads on a fourth grade level.

3. Plan to spend more than the usual amount of time in visiting the patient as the absence of communication skills on the part of the chaplain will necessitate writing very often more than speaking. All chaplains should at least learn the manual alphabet so that they could spell simple sentences to the deaf patient. It would also create a great bond of unity between the priest and the patient.

4. In addition to the basic manual alphabet, it is highly recommended that a few basic signs that would convey key ideas be learned.

5. If hearing persons are in the patient's room and the chaplain speaks with them, keep the deaf person clued in on the nature of the conversation. Otherwise the deaf person will become uneasy and perhaps become suspicious that what is being said concerns the state of his or her health.

6. Remember there is no tone of voice to let the deaf person know you are friendly. Please remember "a smile looks good on any face" and says much more than many words.

7. In reference to the sacraments: Confession is usually written and in most cases, the old form of using Confession forms is being followed. If possible, get the patient to write out his or her Confession. If this is done, return the form or the paper ripped up after you have finished reading it. Let the person dispose of it and destroy it. If a deaf person has understandable speech, urge him or her to use it, but be sure there is privacy as the deaf have no idea of the range or volume of their voice.

8. If possible, there should be a sign over the patient's bed—"Patient Is Deaf." This will assist the chaplain as well as other hospital personnel when they come to the bedside of the patient. It would be extremely important that the chaplain contact the diocesan chancery office to find out whether or not there is any priest in the diocese who works with the deaf. If so, find out his name and address and contact the priest, conveying to him the fact that a

deaf patient is in the hospital. The priest working with the deaf will be conversant with sign language and can supply in the way of motivation, guidance, and consolation what the resident chaplain cannot.

9. Always carry a pencil and some paper with you so that you are prepared for "conversation" with the deaf person. Always be patient with the deaf. Likewise remember that the deaf read very often in the context of how they sign and sign language conveys ideas without regard to good English or grammar construction.

10. In providing reading matter for the deaf, be sure it is simple, about a fourth or fifth grade level, the type of pamphlets that one would give to the uneducated.

11. Most deaf people are very poorly instructed in the faith, due to the fact that there are only about 15 Catholic schools for the deaf in the United States, and only one west of the Mississippi River. The deaf learn slowly and have difficulty with abstract concepts. As a result, their instruction in the one or two hour a week instruction period has to be very limited. By nature, their orientation is to what is concrete and material, what they can experience and see. Do not expect, therefore, that they will understand many of the aspects of the faith that are conversant to the non-deaf.

12. If a deaf person is turned in the opposite direction when you come into the room, perhaps he might feel the vibrations of your walking on the floor as you approach. If not, tap him lightly so that he will turn towards you.

13. The deaf enjoy TV. However, since they are not aware of the volume, it may be necessary for you to instruct them to keep the volume dial at the off position. This is also a caution that you may have to give them when they are speaking with you and there are other patients in the room. Instruct them to try to keep their voice low or even better, to write if it is a matter that is confidential.

14. Deaf people very often wave to get your attention. Very often they make sounds that are upsetting to people. You can explain to the other patients and hospital personnel that this is their effort at speech, when they have no understandable speech, and it is to be accepted without any evidence of surprise.

15. Totally deaf people may have some ability to lip read. If so,

speak very clearly in your normal range and do not overenunciate. Remember, they are taught to lip read as people ordinarily speak.

16. There are individual devices that are helpful to the hard of hearing in regards to Confession and communicating with them. If the hard of hearing person has his own individual hearing aid, be sure that he has it on and that the volume is on when you begin to speak with him. If so, remember it is a miniature PA system and under normal volume of speech he should be able to understand you. There is also a Confession type of hearing aid which is very compact, light, and easy to carry around known as "Confessionaire" manufactured by Audio Engineering Company, Great Neck, New York. It is comparatively inexpensive and all one needs to use it is an electrical outlet since it is equipped with a built-in microphone and a portable hearing aid that the person can put to his ear.

17. If a patient is out of bed or can be moved in a wheelchair, and he has some confidential matters to discuss with you or requests privacy, see if there is an available room that is empty and either walk with the patient or push him in a wheelchair to that room, close the door, and enter into conversation with him.

18. Remember the deaf are very observant. Their visual acuity is extreme. Therefore, always appear happy, give them the impression that you like them, that you are interested in helping them. Never give the impression that you are harassed, in a hurry, upset, or anything of that nature. You convey to them the message of the Church. To the deaf, you are the Church and how they see you very often is how they see the Church.

Blindness

1. It is extremely important that we have a sense of what it is to be blind. At the institute occluders were used. However, if one were to close their eyes and try to make their way around the room, it might achieve a similar purpose.

2. Blind people experience great frustrations. For example, (a) they are not able to see what they are doing, (b) they are constantly aware of the darkness in which they live. To understand them, it is extremely important to realize that they are constantly coping with these frustrations. It is also important to understand some of the

problems of blind people. Their greatest problem is the attitude of the sighted world toward blind people, for example, many of the fallacies that are current notions among those who have sight, such as, because they are blind, they are not capable of skills. Many think that they have mental problems, they are thought to have a void, and people confuse the fact that because they do not have sight that they cannot have visualization. Perhaps one of the greatest fallacies and the most incorrect approach to the blind is one of pity, feeling sorry for them. The blind themselves have mobility difficulties, particularly, independent movement is a problem. They can be trained to use dogs, some can be trained to use canes. However, there are many blind who for a variety of reasons can learn neither of these and, therefore, are dependent upon a human guide for movement. Some blind are trained to move around with a seeing eye dog. Others are trained to cane travel. There are others who never can achieve either of these two forms of mobility. It is always extremely important that we take the blind person as an individual, who has abilities and talents, is capable of enjoying the majority of things that the normal sighted person enjoys and whose limitation is only in the area of lack of sight.

Following are some practical hints in dealing with the blind person, especially if in visiting a blind person there is occasion to walk with him or her from the room to a solarium or elsewhere.

1. Let the blind person take hold of your arm—the motion of your body informs him what usually to expect. Don't push a blind person ahead of you. In narrow aisles—walk ahead of the blind person and let him follow you—he could put his hand on your shoulder in this situation.

2. If you are a third party walking with the blind and his escort —don't take him by the arm or try to guide him. Just walk along in step, engage him in conversation, and let the blind person be guided by his escort.

3. Don't try to "carry" a blind person when assisting him to cross a street or to go up and down stairs, or to avoid bumping into beds, desks, chairs, etc., or to enter a vehicle or to climb up the stairs. You need only to guide his hand to the handle or the rail, or vocally inform him as to what obstacles are present and he will do the rest.

4. If you are in the patient's room when the tray is served, mention what is on the blind person's plate so that he will know how to handle the food. Use the clock system, for example, tell him that his meat is at 6 o'clock, that is, the bottom part of the plate nearest to him, the potatoes are at 3 o'clock to his right, etc.

5. When food is served to the blind person, mention where it has been placed so that the individual will not accidentally knock over a glass, a paper cup, some sherbert, cup and saucer, etc.

The blind have no sixth sense, even though people very often feel that they do. Usually a blind person has a sense of hearing and it is highly developed. The sense of hearing helps the blind person in judging depth, space and distance of objects.

There are some deaf people who are also blind. There is only one way to communicate with a deaf-blind person and that is by spelling each word into the person's hand, using the manual alphabet of the deaf. There are a limited number of deaf-blind people who may have a steel slate with the raised letters of the alphabet. If so, you can take their hand and with whichever finger they extend, be it the index or middle finger or whatever finger, touch the letters spelling out the words so that they will know what you wish to say to them. If this type of person is conversant with Braille, then, of course, they can profit from material that is in Braille. If so, it may be necessary for you to contact the local organization for the blind to obtain a volunteer Braille transcriber who would put into Braille on the special paper, whatever message you wished to convey to them.

Some practical hints in dealing with the blind:

1. Identify yourself as soon as you come into the patient's room, for example, say I am Father - - - - -. I am the hospital Chaplain, etc. Tell the person why you dropped in to see him or her. (With a deaf-blind person, you may have to go right up to the bed and take his hand and let him feel your Roman collar.)

2. As you move closer to the bed or the chair, either continue talking and or touch the patient to let him become aware of your location.

3. Do not move the furniture or articles as they are set up in the room—this can confuse or distress the patient.

4. If the patient is new, you can explain the hospital garments to him and you could let him Braille objects in the room to become acquainted with his surroundings.

5. Offer friendly tips to candy stripers and other volunteers who may come in contact with the patient who is blind—if a blind person receives mail while you are visiting, offer to read it to him and describe the card if it is a greeting card telling him about the colors, any decorations on it, etc.

6. If flowers are delivered, describe them, and let the patient Braille them as well as smell them.

7. A radio is very important to the blind person, however, many blind persons do "listen to TV." During general conversation, turn the radio down or turn it off as the blind person must concentrate in order to hear as he can no longer depend on facial expressions to aid him in interpreting what is being said.

8. Do not talk to a blind person as though he were deaf, and do not address him through the nurse or doctor or another third person. Direct your questions and all of your conversations directly to the patient himself.

9. Do not leave the door ajar when leaving his room; a half open door is the most dangerous obstacle a blind person can encounter. Either leave it fully closed or see that it is pushed back fully opened against the wall and parallel to it.

10. Blind patients should have a sign over the bed—"This Patient is Blind"—it could appear that he is ignoring other people unless this information is conveyed.

11. Indicate whether or not there is another person present in the room if the blind person desires to go to Confession. If someone is present, suggest that they talk very, very low.

12. Touch the lower lip or his chin very lightly when you are distributing Holy Communion to a blind patient. It may also be helpful to say "you can open your mouth and extend your tongue now."

13. If a blind patient is to be anointed, and they are conscious, explain what you are going to do before each particular part of the anointing.

It is very important to remember that all blind people do not know Braille.

There are many organizations that help the blind: The American Foundation for the Blind—this is a private non-profit agency that carries on research, collects and disseminates information concerning the blind, and advises and gives counsel on matters that improve and strengthen services to blind people. For free literature, write to the American Foundation for the Blind, 15 West 16th Street, New York, New York 10011.

The National Society for the Prevention of Blindness—studies the causes of blindness in an effort to eliminate their existence. It also serves as a clearing house for professional groups directly and indirectly responsible for saving sight. Their headquarters are 79 Madison Avenue, New York, New York 10016.

The Xavier Society for the Blind, 154 East 23rd Street, New York, New York 10010, supplies information, books for the blind in Braille and in large print. This is the resource for all religious literature for blind people.

As you may know, the blind can receive books, records, etc. through the mail without cost. All that needs to be printed on the package is "Printed Material for the Blind." There is a large area of assistance to the blind in what is known as "Talking Books." The Library of Congress receives funds to maintain libraries for the blind, that is, large print literature, a music library, and books in the form of Braille, talking disks, and tapes, and provides the instruments, such as tape recorders and victrolas for the use of these assets to the blind.

The blind or physically handicapped person will be supplied with a free Government-owned talking book machine by mailing a statement from a doctor, nurse, social worker, clergyman, librarian, teacher, or any other professional person to the Library for the Blind and Physically Handicapped Division of the Library of Congress, Washington, D.C. The statement should include the disabled person's full name and address and should describe the disability which prevents him from reading regular print. A wide choice of books and magazines on records and tapes is available. The reader returns his records postage free by reversing the mailing label and taking the container to a package mail-box or post office.

The Physically Handicapped

When we speak of the physically handicapped, we realize that is a very broad title. However, we are relating particularly to those in wheelchairs, on crutches, who use braces, epileptics, spastics, people who have cerebral palsy, muscular dystrophy and multiple sclerosis. Ordinarily speaking, we are not including people who are physically handicapped as a result of an automobile accident or some other type of physical occurrence.

Expect to receive a certain amount of "flak" from the physically handicapped person or their family, due to the lack of interest and/or services provided by the Catholic Church for this population. This is an objective truthful fact and we must cope with it. Likewise, because there are not as many public services for this category of handicapped person as there should be, the rancor of both the individual handicapped person and family is very often heightened.

Give yourself double the amount of time you had planned to give any other patient when you come to the hospital room. The physically handicapped people need time to express their thoughts. Many of them have great problems in expressing themselves.

2. If the person has a severe speech problem, do not be embarrassed if you have to ask him to repeat. They are quite used to that and in fact expect it. They would be more offended if you bluffed, giving them the idea that you understood and then gave them an incorrect answer.

3. Regarding speech: do not anticipate the words of a cerebral palsy patient, but give him the time he needs to speak. This is very disconcerting to a handicapped person and is construed by them as being "you're too much in a hurry and not interested enough in me." Don't move the equipment of a patient if you tend to like everything in a neat orderly fashion. Most probably everything is in a very specific place for a specific person's needs.

4. Expect a great deal of unreal requests from the physically handicapped. They are always seeking for better transportation, removal of architectural barriers, a variety of recreational activities. Many of their requests cannot be fulfilled by either an individual chaplain or the Church. Many of them require legislation on

the local level. One copes with them by listening and agreeing with them and assuring them that whatever the person can do to affect change in their behalf, they would be happy to do it.

5. In reference to the Sacraments, many physically handicapped have problems swallowing. It may be necessary to give them just a small part of the Host and at times even to float the small particle on a spoonful of water. Always be sure that there is a glass of drinking water available as many of them, even though they will not ask for the water, actually do need it to assist them to swallow. With many who have severe speech problems, Confession is a great problem. If they write, deal with them as you would a deaf person, tearing up the written Confession and giving it to them to destroy. If they cannot write, and many physically handicapped cannot hold a pen or pencil, or if they do, their writing is not distinguishable, the best thing to do is to tell them that you will ask questions and they can respond by shaking their head negatively or affirmatively.

The Mentally Retarded

The Parents of the Newborn Mentally Retarded Child: One of the very difficult areas in dealing with the retarded that the Chaplain will face is the occasion when the mother has given birth to a baby who is definitely retarded. Invariably this is a baby with Downs Syndrome, more commonly known as a mongoloid. Many parents will refuse to take the child home from the hospital. Others are in such a great state of trauma, usually brought on by fear and questioning concerning how they are going to handle the child, that much careful guidance is needed. The following are some practical suggestions:

1. Remember the parents have great trust in their doctor and have been dealing with him for at least nine months. They believe he knows all there is to know about babies. However, there is a vast area of ignorance on the part of the medical profession concerning the retarded.
2. Often doctors are not aware of the potential of the retarded child. This is *NOT* his field. He is basing his knowledge on very little experience, yet parents believe him. It makes it very difficult to convince them.
3. Medical people often follow the idea that retarded people are "imbeciles," and that they should be "put away"; they should be "with others of their kind."

4. Retarded people have a right to live just as much as you or I and the denial of that right is as sinful as the denial of the right to life to a non-handicapped child.

5. If we do not believe in abortion—if we believe that a human being has a right to life—then we must give him that right—not to an existence in an institution, but life to his full potential.

6. It is extremely important to realize that it is not possible for a doctor to truly know that a child with Downs Syndrome will never be able to walk, talk, relate to others, smile, relax, enjoy, relate, etc. Yet doctors very often use these so-called inabilities as convincing arguments against the parents.

7. It is important to remember that many mongoloids are educable, learn to read and write, to travel, to hold a job (it might be interesting to keep in mind that in the New York City General Post Office there are more than sixty mongoloid retarded individuals working as full-time Civil Service employees in maintenance work). Many of them are even on a lower level than the mongoloid who is educable because many of them are mongoloids who are only trainable.

Responsibility of the Chaplain in this Regard:

1. Become knowledgeable about programs and services in your area so that you may pass this information onto the parents.

2. Try to find a parent of the retarded child who will come and speak to the parent of the newborn infant. She can speak from experience.

3. Parents are not in a position to accept from you or anyone else the cliche about "God must love you very much to send you such a cross." Using that invariably only antagonizes the parents.

4. Permit the person time to get his feelings of anger against God and everyone else out of his system. These feelings must come out eventually and once they have ventilated them, even if it is to yourself, it is easier to deal with them on a more rational basis.

5. Try to get the parents talking to one another about this problem. Very often both husband and wife have a sense of shame and are secretly blaming themselves and are unwilling to discuss the problem between themselves.

6. Do not presume that the parents will both know. Often the doctor will tell the husband about the problem, but does not tell the wife. The wife will know by looking at the child that something is wrong, but might not want to mention it to her husband lest she should upset him. This can go on for months before they start to share the problem. Try to bring them to an immediate realization of their problem and encourage them that it is not an insoluable problem, that they can get all the love and joy and peace from this handicapped child that they had anticipated as they anxiously awaited the birth of their child.

7. Do not go along with the doctor's recommendation just because "he is a doctor" and must know what he is talking about. Have courage to stand up for the truth even if it means taking a stand in opposition of the medical profession and even the administration of the hospital.

Helpful Hints for Chaplains Who Meet the Retarded:

1. When the retarded patient is in the hospital, he could be chronologically a child, a teenager, a middle-aged person, or even an older person. However, remember that every retarded person is functioning somewhere on a child's level. It is safe to presume that the teenager, middle-age and older person, has a mind of a young child, perhaps seven or eight years of age. If the retarded person is a child under twelve, it is safe to presume that you can subtract two or three years from their chronological age and get a fairly accurate idea of the functioning level of the retarded child.

2. Use small words, not abstract words. Instead of asking "is it over there?", ask "it is on the table?" If you are commenting on the brightness of a magenta bathrobe, use purple instead of magenta.

3. Talk slowly at all times. Do not use long, drawn-out sentences. Do not ask five questions in three seconds.

4. Be willing to listen. The retarded have feelings, fears, expectations and hopes. Take the time to listen to them, especially since many others will not, and this is even true frequently of members of their own families.

5. If a parent is present, do not talk around the retarded person. Try to include him in the conversation by asking him simple questions, directing simple bits of information towards him, etc.

6. Be constantly aware that mental retardation is *NOT* mental illness. A mentally retarded person simply develops at a slower pace than normal society, but is not disoriented to society.

7. Some mentally retarded will be on tranquilizers because they are hyperactive. This simply means they are overactive and should not be confused with being mentally ill or emotionally disturbed.

8. Mentally retarded people are members of the Mystical Body and many have received the Sacrament of Communion. Many others have received the Sacrament of Penance. It is good to keep in mind that every retarded child regardless of his functioning level is entitled to the Sacrament of Confirmation in addition to Baptism. It may be of interest to know that religious authorities working in the field of the retarded indicate that on an average with patience and simple preparation, 75% to 80% of the retarded can be brought to the level of the minimum requirements that are necessary for the reception of the Sacrament of the Holy Eucharist. The best policy is to check with the parents or the guardian to ascertain this information. Many times, the retarded child will not answer accurately, but rather than deny Communion to a sick person because he is retarded, make your decision on objective truth.

9. The Chaplain should acquaint himself with what services are offered by the diocese and who is the priest involved. If there is not a priest, he should endeavor to ascertain what religious are working with the retarded. Likewise, it would be helpful to at least be familiar with the name and address of at least one or two major organizations working for the

retarded in the area in the event that parents are seeking assistance.

IN SUMMARY

General Thoughts on the Handicapped:

1. When visiting persons with a handicap, remember first that they are persons and then recall that they happen to have a handicap. It is essential that we do not screen people out because of their handicap, but rather screen them in as persons and then take into account the limitations, mental and physical, that follow upon the handicapping condition.
2. Time and patience both are essential. The ability to really listen is essential. Handicapped people very often are cut off, isolated, and restricted, frequently the greatest act of charity is just affording them some time, listening to them and indicating to them that you do care.
3. Know what is available in the way of services and programs for the handicapped in your diocese, as well as what is available from other service agencies.
4. People who have a handicap can also have a personality. Do not throw them all into one big, broad category—THE HANDICAPPED. They can be quiet, out-going, hostile, anxious, obnoxious, spoiled, altruistic, etc.
5. Invariably the handicapped have a great many of the needs and human services that are common to many people. They may have housing needs, welfare needs, material needs, such as, financial assistance, food, clothing, transportation needs, employment needs, etc. If we are to exercise the corporal works of mercy, it is important that we remember the handicapped also should be recipients of them.
6. Remember the Chaplain always represents the Church. By your attitude, the Church is to be judged.

Appendix

OUTLINE OF A COURSE OF MEDICAL ETHICS FOR HOSPITAL NUNS OR STUDENT NURSES

Introductory Notes:

1. This outline was planned to be a four-hour college course (43 classes of 70 minutes).
2. The textbooks and page numbers where the material is presented best are given:

MCA =McAllister, *Ethics*
ME =McFadden, *Medical Ethics*
Kelly =*Medical Moral Problems*
Healy =*Medical Ethics*
Mim =O'Donnel, *Morals in Medicine*
Häring=Häring, *Medical Ethics* (Fides, '73)
(Excellent up-to-date-bibliography)

Obstetrical Ethics:

1. Direct Abortion	ME 119-121, 132-144, 147-164
2. Indirect Abortion	ME 167-187; Häring 94-119
3. Family Planning and Rhythm	ME 93-116; Häring 60, 86-87
4. Artificial Contraception	Kelly 149-167; Häring 85-106 *passim* Cavanagh, *Fundamental Marriage Counseling*, 294-296, 261-263
5. Drugs with Contraceptive Effects	ME 79-84, 89; Cavanagh 551-556; McCormick, *Homiletic and Pastoral Review*, 692-700
6. Sterilization	ME 281-296, 304-305; Häring 40, 90-91
7. Fertility Tests	Cavanagh 312-317, 330-342
8. Artificial Insemination	ME 53-62; Cavanagh 318-329; Häring 91-94

Foundations of Ethics:

1. Nature and Value of Ethics	MCA 3-14; ME 1-9
2. Truths Basic to Ethics	Healy 1-4; ME 4-6; Mim 3-8
3. Law and Inalienable Rights	MCA 65-75; Kelly 1-4; Healy 10-12; Mim 11-12, 21-22; Theological Studies, June 1963, 222
4. Conscience and Imputability	MCA 110-112; ME 16-21; Mim 21-25

Principles of Ethical Judgement:

1. Morality of Human Acts	Mim 34-39
2. Principle of Double Effect	Kelly 12-16; ME 27-33; Häring 96
3. Principle of Totality	Kelly 8-11; ME 255-258; Mim 76-78, 127-128
4. Consent of Patient	Kelly 36-49; Ficara 133-134; Mim 55-59; Häring 215-217

Ethical Problems Regarding Life:

1. Preserving Life (see #4 above)	Kelly 62-67; MCA 169-177; ME 207-208; Mim 60-61
2. Ordinary and Extraordinary Means	Kelly 128-141; ME 227-249; Healy 60-89; Mim 61-62, 67-74; Häring 140-150
3. Innocent Life	MCA 216-234
4. Capital Punishment	MCA 256-261
5. Euthanasia	Kelly 114-119; ME 208-214; Healy 266-270; Mim 60, 214; Häring 140-150
6. Philosophy of Suffering	ME 218-223

Ethical Problems Regarding Mutilation:

1. Nature and Morality	MCA 240-255; Healy 121-ff.; Mim 75
2. Surgery	Kelly 245-248; ME 258-265, 268-270; Mim 82-84
3. Use of Drugs	Mim #23, p. 362; Häring 189-198
4. Mutilation of Body	Kelly 252-260; ME 258-259; Mim 84-90
5. Hypnosis and Narcoanalysis	Kelly 282-287; Healy 263-265; Mim 106-107
6. Organic Transplants	Kelly 249-252; ME 265-268; Mim 79-81; Häring 120-130 *passim*
7. Autopsy and Embalming	ME 276-279; Mim #25, p. 362
8. Human Experimentation	Kelly 261-265; ME 249-255; Mim 115; *Theological Studies*, September 1955, p. 385-391; Häring 208-217

Cooperation in the Unethical Actions of Others:

1. Kinds and Licitness	Kelly 332-335; ME 327-342; Mim 44-50
2. Specific Cases	Healy 101-111; Intercourse-Mim 285-287; Surgery-Mim 50-52

Professional Secrecy:

1. Good Name	MCA 262-270; ME 359-384; Mim 319-334; LaRochelle 285-293; *Linacre Quarterly*, Feb., 1962
2. Privacy	Ficara 133
3. Consultation	Kelly 51-58
4. Psychic Privacy	*Theological Studies*, June 1963, p. 213-217

Contracts:

1. Nurse and Patient	MCA 280-296; ME 416-ff.; Healy 17, 22, 24-32
2. Nurse and Hospital, Doctor and to Profession	MCA 297-303; LaRochelle 273-277, 299-303

Property Rights of Patients:

1. Theft	MCA 271-279; ME 343-348
2. Unjust Damages	MCA 235-238
3. Unjust Charges	
4. Right to Knowledge of Condition	Mim 353-356; Kelly 38-39; *Linacre Quarterly*, Nov. 1955

This course has been compiled and successfully used by Father Isidore Langheim, O.F.M., Chaplain. Cleveland Psychiatric Institute, Cleveland. Fr. Isidore is certified as a Supervisor, NACC.

PROFESSIONAL STANDARDS FOR MEMBERSHIP AND CERTIFICATION NATIONAL ASSOCIATION OF CATHOLIC CHAPLAINS

BACKGROUND

The ministry of the hospital chaplain is best provided by priests who have received special training to equip themselves for this demanding yet most rewarding opportunity to serve the mentally, emotionally, physically and socially ill and handicapped. Individuals in an institutional setting, in addition to their primary illness, have the burden of being set apart from society. Special understanding of the relations among religious faith, illness and emotional and mental conflicts is required for a truly helpful ministry to the institutionalized person.

A clergyman with specialized training in the institutional ministry is better able to understand and appreciate his strengths and limitations, and thus to fit into the health care setting. It is as important for the chaplain to know what not to do as what to do. The thousands of individuals who are away from their own homes and churches for a temporary period each year in hospitals and institutions need a special type of ministry. The chaplain, basically, is their pastor. He needs the personal, educational and experiential qualifications to minister to their individual needs in an understanding manner.

The continuing need for well-qualified chaplains requires specialized training. This education needs to be under the supervision of experienced chaplain supervisors. The net result of such training will be better service to patients and residents of health care facilities; greater interprofessional respect and cooperation; better working relationships in the community between the clergy and other professions concerned with helping people; and deeper insight into the personality strengths and resources of the chaplain himself.

OBJECTIVES

The purpose of these professional standards is to serve as a guide in the selection of hospital chaplains. The objectives of these standards therefore are:

1. To assure the fitness of those appointed as chaplains.
2. To promote the effectiveness and professional growth of the chaplain.
3. To secure from public and private health care facilities the due and proper recognition of the Catholic chaplain.

Recommended Qualifications for Health Care Facility Chaplains

- A priestly and Christ-like disposition which is tolerant, compassionate, and understanding of patients who are in an abnormal environment.

- Interest—The priest should have a proven concern for the apostolate to the sick.
- Courage—He must create and sustain the position of the chaplain and the chaplain's relationship to administration to prevent abuses which might endanger a positive religious program within an institutional setting.
- Prudence and emotional stability—These are manifested by a mature approach in establishing healthy and effective relationships with the patients and personnel.
- Friendliness and sociability, a realization of the great value of human relations—being agreeable and approachable enables the chaplain to get along well with all persons involved in the hospital or health related institution.
- Ability to cooperate and work with others on a professional level—This requires good judgment on the part of the chaplain in arranging his apostolate and program to cooperate fully with the team approach of patient care, and the hospital schedules.
- Initiative and resourcefulness—These enable him to judge where improvements can be made and thereby advance his services and programs.
- Sufficient interest in reading and study—The priest thus remains current with contemporary thought in the Church and the hospital and medical field.

STANDARDS FOR MEMBERSHIP

Any chaplain who is actively serving in an institutional setting is eligible for membership in the National Association of Catholic Chaplains provided he fulfills the following minimal requirements:

1. Ordination to the priesthood and good standing in his diocese or religious order.
2. Four years of college—The following courses or their equivalents will be required of all candidates: Biology (human biology); health and physical education (personal and community activity); social sciences (principles of sociology, social problems, American minorities, Christian social principles); speech (public speaking and interviewing); education (philosophy of education, educational psychology, techniques of education, special methods in the teaching of religion); liturgy (fundamental liturgy); guidance (moral guidance); philosophy (logic, philosophy of nature, epistemology, rational psychology, ontology, theodicy, ethics).
3. Four years of theology—The following courses or their equivalents will be required of all candidates: Dogmatic theology (God and creation, Incarnation and redemption, grace and justification, sacramental theology I, sacramental theology II); moral theology (moral principles, morality of human acts, precepts of the theological virtues, selected precepts of the Decalogue, social and commutative justice, states in life, the Sacrament of Penance, the Sacrament of Matrimony, the Sixth and Ninth Commandments, pastoral practice); Sacred Scripture (exegesis of the Old Testament, history, exegesis of the New Testament, application of Sacred Scripture to life); speech (advanced composition, sermon building, persuasion in sermons, types of public address, types of sermons); liturgy (sacramental liturgy, the administration of the sacraments under unusual circumstances).

STANDARDS OF CERTIFICATION

After a chaplain enjoys membership in the National Association of Catholic Chaplains, he may then apply for certification in any one of the following categories:

1. Chaplain, General Health Care Facility
2. Mental Health Chaplain
3. Acting Chaplain Supervisor, General Health Care Facility
4. Acting Mental Health Chaplain Supervisor
5. Chaplain Supervisor, General Health Care Facility
6. Mental Health Chaplain Supervisor

A Board of Examiners, consisting of five members appointed by the General Secretary of the United States Catholic Conference with the Executive Secretary of the NACC acting as secretary to this Board, will review the professional training and qualifications of priests seeking certification as chaplains. The Board will make nominations of those approved to the United States Catholic Conference for certification.

The Board will also review and evaluate the training programs being conducted by chaplain supervisors who seek accreditation for these programs. Such accreditation will be based on criteria already established and listed below.

CERTIFICATION REQUIREMENTS

Nomination for certification will be made according to the judgment of the Board of Examiners who will consider the fulfillment of the following requirements:

1. Membership: Active membership in the National Association of Catholic Chaplains based on the criteria listed above as standards for membership.
2. Experience: Two years of satisfactory pastoral experience subsequent to ordination.
3. Training: The chaplain must have completed either the training program sponsored by or one approved by the National Association of Catholic Chaplains. It is understood that this training course will be compatible with the grade of certification requested. The various programs are listed below under the specific grade of certification.
4. Evaluation Fee: An evaluation fee of twenty-five dollars ($25) shall accompany each application. No refund will be made in the event that the request for certification is denied.
5. Time: Applications may be submitted at any time. However, the Board of Examiners meets quarterly in March, May, September, and December.

A. *Chaplain, General Health Care Facility*

1. All the above requirements (Recommended Qualifications and Standards for Membership)
2. One quarter of twelve weeks—480 hours. Recommended curriculum:
   a. The Hospital Today — 12 hours
   b. Relationship of Chaplain to Various Departments — 15 hours

c.	Theology of Hospital Apostolate	18 hours
d.	Physical and Mental Handicaps	9 hours
e.	Principles of Pastoral Counseling, Group Dynamics and Group Therapy	30 hours
f.	Seminar on Functions and Concerns of General Hospital Chaplains	20 hours
g.	Assigned Reading and Individual Consultation	84 hours
h.	Supervision of Pastoral Ministry and Counseling	24 hours
i.	Attendance at Clinical Conferences	20 hours
j.	Supervised Practicum—Mass, Sacramental Ministry, Ward Visitation, Counseling with Patients and Families, Consultation with Pastors and Professional Staff, etc.	248 hours

Academic—232 hours
Supervised Practicum—248 hours
Total—480 hours—twelve weeks—one quarter

B. *Mental Health Chaplain*

1. All the above general requirements (Recommended Qualifications and Standards for Membership)
2. Three quarters of 12 weeks each (total 36 weeks)—i.e., one academic year. Recommended Curriculum:
   Psychodynamics and Psycho-pathology—48 hours—basic theory underlying personality adjustment and maladjustment, with emphasis on dynamic concepts, and a detailed consideration of psycho-pathological syndromes.
   Theories of Personality—36 hours—critical evaluation of both psychiatric and psychological theories of personality: structure, dynamics, development and adjustment.
   The Psychiatric Hospital—12 hours—orientation to its mission and management.
   Techniques of Pastoral Counseling—36 hours—theoretical foundations and practice of pastoral counseling: personal frame of reference in counseling. Should include evaluation of counseling interviews with supervisor, and an evaluation of the techniques of client-centered counseling from the point of view of pastoral counseling.
   Introduction to Psychological Testing—8 hours—orientation to an understanding of the purposes and uses of clinically administered intelligence and personality tests.
   Somatic Treatments and Drug Therapy—6 hours
   Group Dynamics and Group Therapy—24 hours—principles of group interaction with emphasis on counseling and therapeutic groups.
   Introduction to Contemporary Systems of Psychotherapy—24 hours—a survey of the newer viewpoints, theories, techniques of psychotherapy.
   Seminars on Functions and Concerns of Mental Hospital Chaplaincies—36 hours—e.g., role of chaplain, chaplain and volunteers, etc.—trainee responsible for presentation and discussion.
   Attendance at Clinical Conferences—108 hours
   Supervision of Pastoral Ministry—36 hours
   Supervision of Pastoral Counseling—36 hours
   Assigned Reading and Individual Consultation with Supervisor—288 hours

698 hours curriculum and supervision
742 hours supervised practicum (pastoral ministry by trainee in direct patient contact: Mass, chapel and ward Confessions, ward Communions, ward visitation, pastoral counseling, consultations with professional staff, etc.)

Total—1440 hours

C. *Acting Chaplain Supervisor, General Health Care Facility*

1. Certification as a chaplain, general or mental health care facility, by the United States Catholic Conference.
2. A minimum of one year full time chaplaincy experience after above certification.
3. Three letters of recommendation from responsible persons in the institution where chaplain ministers. The applicant will send the names of five persons and three of these will be asked for letters.
4. Personal interview with a member of the Board of Examiners or delegate.

NOTE: This certification will be valid for one year only from date of issue.

D. *Acting Mental Health Chaplain Supervisor*

1. Certification as mental health chaplain by the United States Catholic Conference.
2. A minimum of one year full time experience in mental health chaplaincy after above certification.
3. Three letters of recommendation from responsible persons in the institution where chaplain ministers. The applicant will send the names of five persons and three of these will be asked for letters.
4. Personal interview with a member of the Board of Examiners or delegate.

NOTE: This certification will be valid for one year only from date of issue.

E. *Chaplain Supervisor, General Health Care Facility*

1. Certification as Acting Chaplain Supervisor, General Health Care Facility.
2. During the year when the above certification is valid, the acting supervisor must demonstrate his ability to supervise a trainee or initiate a training program in his institution.
3. A personal interview with a member of the Board of Examiners or delegate.
4. Payment of an additional $10 evaluation fee.

F. *Mental Health Chaplain Supervisor*

1. Certification as Acting Mental Health Chaplain Supervisor.
2. During the year when the above certification is valid, the acting supervisor must demonstrate his ability to supervise a trainee or initiate a training program in his institution.
3. A personal interview with a member of the Board of Examiners or delegate.
4. Payment of an additional $10 evaluation fee.

GUIDELINES FOR SUPERVISION

The following guidelines represent the work of several experienced Chaplain Supervisors who met in the fall of 1969. After various modifications, they were adopted by the Board of Examiners, Department of Health Affairs, United States Catholic Conference on June 23, 1970.

It is understood that these guidelines represent only one method of supervision. Recognizing that it is difficult and, in some instances impossible, for a chaplain to enroll full time as an intern or resident chaplain trainee, a program has been devised whereby he may fulfill the requirements under supervision in his own health care facility. It is this program that is now outlined.

A. Completion of the two week Pastoral Institute for General Hospital Chaplains conducted by the National Association of Catholic Chaplains.

B. Upon completion of the Institute, the chaplain trainee returns to his institutional ministry. There he follows a ten week 400 hour training program under the direction of a certified Chaplain Supervisor. The staff of the hospital serves as the instructing staff of the training program.

C. The chaplain trainee should possess, or have easy access to, an adequate library. Thus he will be able to read and report on the required reading determined by the Chaplain Supervisor.

D. The Chaplain Supervisor will meet once each week to discuss the progress of the trainee with him.

IN-HOSPITAL TRAINING PROGRAM

1. The trainee will meet with the Supervisor and discuss the program as outlined in this presentation. The Supervisor will consider the structure of the trainee's hospital and adjust the program and schedule to fit the situation. An explanation of the purposes and various phases and steps will be made.

2. The Supervisor will arrange to meet with the Superintendent of the hospital and explain this method of achieving certification for his chaplain. He will ask for the cooperation and understanding of the Superintendent as well as his permission to carry out the program.

3. The trainee will be given a schedule of work to be covered. It will bring him in contact with all departments and agencies within his hospital. In each he will review the purposes, functions and methods of operation with the department head or his delegate. It will be left to the trainee to arrange the meeting. The department head or the person giving the instruction will sign the check-off list afterward.

4. A brief resume of each instruction should be made by the trainee. Information that would be helpful to him as a chaplain should be included. Any explanatory pamphlets available from the department under study should be obtained. It is recommended that the resume, pamphlets and other information be placed in a file folder and be properly marked. This will help the Chaplain Supervisor to make his evaluation. The file folders when returned to the trainee give him a well documented file on the hospital organization.

5. At completion of not less than ten weeks, supervisor contacts hospital superintendent for final recommendations.
6. Supervisor forwards his recommendation together with records to the Board of Examiners and returns any worksheets to priest-chaplain.

SCHEDULE OF INDOCTRINATION MEETINGS WITH INSTRUCTORS

1. Hospital Administrator

   Discuss: Chaplaincy certification and how it helps priest, hospital and patients. Ask administrator to explain administrative procedures.

   Exercise: Make organization chart listing all departments and subdivisions. Include names of all persons heading these departments and divisions.

2. Business Office

   Meet with department head or delegate

   Discuss: Patients' payment plans—Blue Cross, Blue Shield, Major Medical. Other types of hospitalization. Cost of hospital operation. Purchase and supply.

   Submit summary of discussion to Chaplain Supervisor.

3. Social Service

   Meet with department head or delegate

   Discuss: Nature and scope of work. Procedures for referring cases, charity cases. Medicare. Other agencies and organizations that are dealt with, such as Catholic Charities, Public Welfare, etc. Transferring patients to nursing homes, other hospitals, institutions.

   Submit summary of discussion to Chaplain Supervisor.

4. Admitting Office

   Meet with department head or delegate

   Discuss: Admitting procedures. Filing of patient information. Method of informing departments of admissions and discharges. Clergy file. Notification of clergy.

   Submit summary of discussion to Chaplain Supervisor.

5. Information Desk

   Meet with department head or delegate

   Discuss: Visiting regulations. Policy on answering requests for patient information. Other duties of information clerk.

   Submit summary of discussion to Chaplain Supervisor.

6. Dietary and Kitchen

   Meet with department head or delegate

   Discuss: Nature and scope of work. Religious dietary laws. Tour kitchen area and observe work.

   Submit summary of discussion to Chaplain Supervisor.

7. Disaster and Fire Control

Meet with department head or delegate
Discuss: Hospital policy.
Exercise: Prepare a disaster and fire plan for yourself. Give copy of plan to hospital disaster and fire coordinator.
Submit summary of discussion to Chaplain Supervisor.

8. Other Departments (Pharmacy, Central Supply, Housekeeping and Maintenance.)

Meet with department heads or delegates
Discuss: Procedures, regulations, method of operation. Nature and scope of work.
Observe: Department in operation.
Submit summary of discussion to Chaplain Supervisor.

9. Medicine and Surgery

Meet with Chief of Staff and with the head of each medical and surgical department.
Discuss: Services offered, routine and techniques, specialities of each branch: Internal Medicine, Gastro-Intestinal, Contagion and Tuberculosis, Obstetrics and Gynecology, Pediatrics, Surgery, Orthopedics, X-Ray, Pathology, Geriatrics.
Submit summary of discussion to Chaplain Supervisor.

10. Psychiatric and Psychological Services

Meet with Chief(s) of Service(s)
Discuss: Hospital's service to the psychiatric patients. Chaplain's role in this area. Role of psychologist, psychiatric social worker, psychiatric nurse and psychiatric aides. Civil laws pertaining to psychiatric patient and his commitment. State and County facilities available for long-term care.
Attend: Staff conferences
Submit summary of discussion to Chaplain Supervisor.

11. Rehabilitation

Meet with department head or delegate
Discuss: Physio-therapy, occupational therapy and spiritual therapy.
Observe: Rehabilitation in progress.
Submit summary of discussion to Chaplain Supervisor.

12. Clinic Services

Meet with department head or delegate
Discuss: Services available.
Exercise: Make a list of clinical services stating days and time available to outpatients.
Submit summary of discussion to Chaplain Supervisor.

13. Addiction (Narcotic and Alcohol)

Meet with doctor who specializes in these subjects or contact county authorities for asisstance.

Discuss: Various drugs used by addicts. The effects of drugs. Treatment. Legal aspects. County and State facilities. Alcoholism and its treatment. Rehabilitation of addicted persons.

Submit summary of discussion to Chaplain Supervisor.

14. Suicides

Discuss: This subject with Chief of Medicine and psychiatrist. Hospital's policy toward suicide cases. Methods of handling suicide cases.

Submit summary of discussion to Chaplain Supervisor.

15. Emergency Room

Meet with department head or delegate

Discuss: Emergency Room procedures.

Submit summary of discussion to Chaplain Supervisor.

16. Nursing Service

Meet with department head or delegate

Discuss: Relation of Chaplain to department of nursing, including procedures for notifying clergy, organization of department of nursing, special techniques to be observed by chaplain (isolation, etc.), orientation programs, etc.

Submit summary of discussion to Chaplain Supervisor.

17. In Service Medical Education

Meet with department head or delegate

Discuss: Training programs available for interns and resident M.D.'s, registered nurses, student nurses, L.P.N.'s, nurses aides, lab technicians, etc. How many chaplains cooperate in this area.

Submit summary of discussion to Chaplain Supervisor.

PRIEST-CHAPLAIN'S IN-SERVICE INDOCTRINATION

(To be Signed by Appropriate Person in Each Department)

DEPARTMENT	DATE COMPLETED	INSTRUCTOR
Administration		
Business Office		
Social Service		
Admitting		
Information		
Volunteer Service		
Dietary and Kitchen		
Pharmacy		
Central Supply		
Housekeeping		
Maintenance		
Disaster and Fire Control		
Chiefs of Staff of following Services:		
Medicine (Internal)		
Gastro-Intestinal		
Cardiology		
Contagion and Tuberculosis		
Obstetrics and Gynecology		
Pediatrics		
Pulmonary		
Orthopedics		
X-Ray		
Geriatrics		
Pathology		
Psychiatric		
Rehabilitation		
Director of Nursing		
In-Service Training		
Head of Nursing School		
Emergency Room		

SUPERVISING CHAPLAIN'S RECORD

(To be Completed by Chaplain Supervisor)

A. Name of Chaplain _____

B. Name of Hospital _____

Address _____

Telephone _____

C. Hospital Experience _____

_____

_____

_____

D. Courses, Instructions, Conventions, Institutes, pertaining to Chaplain's Hospital Work _____

_____

_____

_____

_____

_____

E. Languages _____

_____

F. Records of Meeting with Chaplain

1. Initial Meeting with Hospital Administrator

Name _____ Date _____

Comment _____

_____

2. Initial Meeting with Chaplain

Place _____ Date _____

Comment _____

_____

_____

_____

3. Meeting with Chaplain to discuss Administration and Administrative Departments

   Place _____ Date _____

   Comment _____

   _____

   _____

   _____

4. Meeting with Chaplain to discuss religious program

   Place _____ Date _____

   Comment _____

   _____

   _____

   _____

5. Meeting with Chaplain to discuss the entire field of medicine and Nursing

   Place _____ Date _____

   Comment _____

   _____

   _____

   _____

6. Meeting with Chaplain to discuss psychiatric, alcohol, narcotics, suicide

   Place _____ Date _____

   Comment _____

   _____

   _____

   _____

G. Supervision Completed

   Date _____

   Comment _____

   _____

   _____

   _____

   _____

   _____

H. Letter to Board of Examiners

OHIO STATE CHAPLAINS ASSOCIATION
INTER-FAITH IN-SERVICE TRAINING PROGRAM

The program of the Inter-faith, In-service Training Course for the term 1967-68 will start at Hawthornden State Hospital, Northfield, Ohio on October 2. The program is available to State Chaplains and to a selected number of the other clergymen and/or advanced seminary students.

Its purpose is to study in depth human behavior in crises; emotional stress, mental illness, social deviation, and mental retardation are centered upon. To foster the essential ingredient of clinical pastoral training, namely, the student-client-supervisor relationship, classes are kept small enough so that this close "working together" can be attained.

Subject matter during the first semester includes courses in Pastoral Counseling and Pastoral Psychiatry as well as Seminars in Abnormal Psychology and a Seminar in Development Psychology. In the second semester the course in Pastoral Psychiatry and Seminar in Developmental Psychology is replaced by a Seminar on Professional Relationships and a course in Social Deviations. Classes are 105 minutes and are held once weekly.

The clinical program includes: 1) An orientation period for acquaintance with the training center; 2) Participation in the program of the centers Chaplaincy Department; 3) Assigned interviews followed by evaluation; 4) Clinical studies presented by the staff; 5) Regular conferences with the Chaplain Director; 6) Participation in group dynamics experience.

This inter-faith, in-service Training Program is approved by the Ohio State Department of Mental Hygiene and Correction and the Ohio Youth Commission for meeting requirements of clinical studies and training necessary for promotion in the Ohio State Chaplaincy Service.

Upon successful completion of the course the participants are granted a certificate from the Ohio State Chaplains Association, Ohio Department of Mental Hygiene and Correction, and the Ohio Youth Commission.

Catholic University of America, Washington, D.C. also grants a Diploma of Accomplishment upon the successful completion of the course.

To cover this amount of work requires two full days, Mondays and Tuesdays; classes will start at 8:30 AM and end at 4:30 PM. Lodging and meals are available at very modest rates. The course also requires that the trainees report on one day's work done in his own institution or parish. It should be noted by State Chaplains contemplating this program that these three days comprise part of his normal work week; this, through directives issued by the Department of Mental Hygiene and Correction and the Ohio Youth Commission.

Anyone interested in applying for academic credit should notify the director of the program so that a copy of the curriculum can be sent to the proper seminary or participating college.

If there be questions or you wish further details, you may call Chaplain Myers, 216-467-7131; or Chaplain Karl, 614-279-9471.

Rev. Ralph J. Karl, OMI
President, OSCA

INTER-FAITH IN-SERVICE TRAINING PROGRAM
OHIO STATE CHAPLAINS ASSOCIATION

TIME	COURSE "A"	COURSE "B"
8:30 to 10:15	Pastoral Counseling Text: Clinebell	Systematic Psychiatry 1st Semester Text: Rowe
	Pastoral Counseling Text: Godin	Seminar in Pastoral Psychiatry 2nd Semester Text: Bibliography furnished
10:15 to 12:00	Seminar in Abnormal Psychology Text: Bibliography furnished	Seminar in Developmental Psychology 1st Semester Text: Bibliography and manual
	Social Deviation Text: Korn-McCorkle	Seminar in Professional Relationships 2nd Semester Text: Bibliography and manual
12:45 to 2:30	Counseling Practicum	Counseling Practicum 1st Semester
	Counseling Practicum	Counseling Practicum 2nd Semester
2:30 to 4:00	Group Dynamics	Book Review Seminar 1st Semester
	Group Dynamics	Book Review Seminar 2nd Semester

First Semester

Oct. 2- 3	Dec. 4- 5
9-10	11-12
16-17	18-19
23-24	
30-11/1	Jan. 8- 9
	15-16
Nov. 6- 7	22-23
13-14	29-30
20-21	
27-28	

Second Semester

Feb. 5- 6	Apr. 1- 2
12-13	8- 9
19-20	22-23
26-27	29-30
Mar. 4- 5	May 6- 7
11-12	13-14
18-19	20-21
25-26	27-28

INTER-FAITH IN-SERVICE TRAINING PROGRAM

OHIO STATE CHAPLAINS ASSOCIATION

Catalogue and Course Description:

A-771 *Pastoral Counseling:* Study of the techniques and methods in the field of counseling: Practicum in the pastoral counseling interview; discussion of pastoral counseling cases.

A-772 *Pastoral Counseling II:* Principles and practices of Pastoral Counseling; recording and discussion of pastoral counseling cases; critical study of procedure and results; group counseling.

A-773 *Seminar in Abnormal Psychology:* Investigation of deviate behavior; pathological mental processes and phenomena.

A-774 *Social Deviation:* Study of the nature of crime and delinquency; its causes; preventive, custodial, and rehabilitation programs and techniques.

B-781 *Systematic Psychiatry:* A systematic study of newer viewpoints in psycho-pathology, psycho-therapy, diagnosis, and treatment.

B-782 *Seminar in Pastoral Psychiatry:* Advanced studies in crises in clinical settings; spiritual needs of individuals, recognition of resources of the Christian faith in ministering to people who are experiencing crises.

B-783 *Seminar in Developmental Psychology:* An advanced study of personality formation; normal growth and development; factors which enhance or interfere with adjustment; character evaluation.

B-784 *Seminar in Professional Relationships:* Organization and administration of institutions; postulates and practices of various disciplines; staff relationships and team concepts; professional organizations; duty roles of chaplains.

A-B *Counseling Practicum*

A *Group Dynamics*

B *Book Review Seminar*

All "A" courses are taught on Mondays. Odd numbers are for first semester and even numbers denote second semester. All "B" courses are taught on Tuesdays.

A-771 Pastoral Counseling

Text: Basic Types of Pastoral Counseling—Clinebell
Introduction to Pastoral Couseling; Counseling Principles—4 classes; Directing in Counseling; Case studies—3 classes; Eclectic Counseling; Counseling Techniques; Types of Counseling; Directive Counseling; Non-directive Counseling; Uses of Directive Counseling; Uses of Non-directive Counseling; Counseling Practicum—8 classes; Examination.

A-772 Pastoral Counseling II

Text: The Pastor as Counselor—Godin
Religious Doctrine and Counseling; Pastoral Roles in Counseling; Transference and Counter-transference; Psychiatric-religious pathologies; Religious Inventories—2 classes; Chaplains Interview with Prisoners; The Chaplain and Delinquents; Counseling with Delinquents; Types of Referral; The Face to Face Group; Group Dynamics—5 classes; Case Presentations—6 classes; Examination.

A-773 Seminar in Abnormal Psychology

Text: Bibliography of readings will be furnished.
Neurosis or Psychosis?; Symptoms of Psychosis; Depression Syndromes; Schizophrenia—2 classes; Depression; The Paraphrenic; Psychosomatic Medicine; Neurology; Mental Retardation; Severely Retarded; Types of mental defectives; Slow Learners with Emotional Disturbance; Treatment and Training for Retarded; Diagnostic Staff—4 classes; Problem Case Conferences—4 classes; Examination.

A-774 Social Deviation

Text: Criminology and Penology—Korn and McCorkle
Purpose of a State Reformatory; Problems of Prosecution; Problems of Rehabilitation and Parole; Problems of the Prisoners; Family Problems in Prison; Correction of Inmates; Alcoholism; Treatment of the Alcoholic; The Narcotic Offender; Drug Addiction; The Homosexual Offender; Personality Disorders; Passive-aggressive Personality; Psychopath; School Dropouts; Youthful Offenders; Juvenile Court Hearings; Definitions of Offenders; Disposition of Cases; Treatment of Delinquents; Probation; Dependent and Neglected Children; Seminar in Delinquency; Examination.

B-781 Systematic Psychiatry

Text: Outline of Psychiatry—Rowe
History of Psychiatric Care; Nature of Symptoms; Terminology; Diagnostic Nomenclature of Mental Disorders; Ego Defenses; Nature of Anxiety; "Mike Makes His Mark"—Movie; "Ninety-First Day"—Movie; Cultural and Family Influences; Ancillary Services; Management Therapy; Theories of Psychoanalysis—2 classes; Techniques of Therapy; Trends in Modern Psychiatry; Book Review Seminar—4 classes; Chaplain Supervisor Conference—2 classes; Examination.

B-783 Seminar in Developmental Psychology

Text: Bibliography of Readings will be furnished
Development of Personality; Personality Structure; Defense Mechanisms; Dynamics of Adjustment; Personality Development—Conception to 2; Personality Development—2-6; Child Psychiatry—6 to 13; Personality Development—14 to 18, 18 to 35; Personality Development—35 to 65, Geriatric development; Influence of Education and Training; Psychometrics; Mental Assessment; Organic Evaluation; The Deaf Child; Observational Study of Socialization, Physical development, Behavior, and truncated development of Retarded Children—8 classes; Examination.

B-782 Seminar in Pastoral Psychiatry

Text: Bibliography of readings will be furnished.
Pastoral Psychology; Public Worship and the Patient; Religious Symptomotology; Impact of Religion on Society; Compulsion and Religious Freedom; The Many Faces of Hostility; Helping the Grief Stricken; Cell Visitation; Chaplains Role in a House of Correction; Religious Lesson Plans for the Retarded; Religious Source Materials—Catholic; Religious Source Materials—Protestant; Audio-Visual Aids; Religion for the Deaf Child; Religious Lesson Plans taught and evaluated—4 classes; Chaplain-supervisor conferences—4 classes; Examination.

B-784 Seminar in Professional Relationships

Text: Bibliography in Readings will be furnished.
Departmental Structure; Administrative Organization of an Institution; Accreditation Agencies and Professional Organizations; Nursing Services Department; Psychiatrist and the Chaplain; Rationale of the Social Work Profession; Specifics of Social Work; Alcoholics Anonymous; Parole Officers; Overview of the Court Organization; Problems in a Correctional Institution; The Chaplains Budget—2 classes; Team Meetings (Ward Conferences)—5 classes; Administrative Staff conferences—5 classes; Examination.

COMMONLY USED GLOSSARY OF TERMS

The scope of this glossary prohibits the inclusion of every conceivable medical term. Some terms, because of common and popular use, have not been included. The reader is referred to the various standard dictionaries and glossaries readily available in a medical library of health care facilities.

* * * * * *

ABREACTION Emotional release or discharge resulting from recalling to awareness a painful experience which has been forgotten (repressed) because it was consciously intolerable. Its therapeutic effect occurs through discharge of the painful emotions, desensitization to them, and often, increased insight.

ABUSE To mistreat; may be verbal or physical mistreatment.

ACHIEVEMENT, ACADEMIC The level of skill reached in school work; usually expressed as grade level, which may be based on grade successfully completed or upon an achievement test.

ACHIEVEMENT TEST Test designed to measure knowldege in academic areas such as reading and arithmetic.

ACROMEGALY A chronic disease caused by oversecretion of the growth hormone of the anterior lobe of the pituitary gland. Its presence in the adult results in massive features.

ACTING OUT Expression of unconscious emotional conflicts or feelings of hostility or love in actions that the protagonist does not consciously know are related to such conflicts or feelings. May be harmful or, in controlled situations, therapeutic (e.g., children's play therapy).

ADDISON'S DISEASE A disease caused by a deficiency of the hormones secreted by the adrenal cortex.

ADJUSTMENT The relationship between the individual, his inner self, and his environment.

AGGRESSION In psychiatry, forceful attacking action, physical, verbal or symbolic. May be realistic and self-protective, including healthful self-assertiveness; may be unrealistic and directed outwardly toward environment or inwardly toward self.

AKATHISIA Originally, a difficulty in sitting down. More recently broadened to include restlessness and uncontrolled muscular movements, sometimes seen as side effects in the use of certain psychotropic drugs, such as the phenothiazines.

ALCOHOLISM The overuse of alcohol to the extent of habituation, dependence, or addiction. Alcoholism is medically significant when it impairs or threatens physical or mental health, or when it hampers personal relationships and individual effectiveness.

ALKALOSIS A condition in which the alkalinity of the body is increased. It may be caused by excessive ingestion of sodium bicarbonate or may result from excessive vomiting.

AMBIVALENCE The coexistence of two opposing drives, desires, feelings or emotions toward the same person, object or goal. These may be conscious or partly conscious; or one side of the feelings may be unconscious. Example: love and hate toward the same person.

AMBULATORY Walking; able to walk.

AMENORRHEA Absence of menses. It occurs normally before puberty, during pregnancy and lactation, after menopause, and in some emotional disorders.

AMNESIA Pathological loss of memory; forgetting; a phenomenon in which an area of one's experience or recollections is forgotton and becomes consciously inaccessible. It may be of organic, emotional, or mixed origin, and sharply circumscribed in limits of time.

ANALYTIC PSYCHOLOGY The name given by the Swiss psychoanalyst, Carl Gustav Jung (1875-1961) to his theoretical system which minimizes the influence of sexual factors in emotional disorders and stresses mystical religious factors.

ANAMNESIS The developmental history of an individual and of his illness, especially a patient's recollections.

ANASTOMOSIS The point at which two parts are surgically joined together.

ANEURYSM Dilation of a blood vessel into a sac-like bulge, frequently occurring in late syphilis. It may cause pressure on adjoining organs.

ANOREXIA Loss of appetite. It may occur with many illnesses and often is one of the earliest symptoms.

ANTIBODY An immune substance produced within the body in response to a specific antigen. The antibody is specific only for the specific substance that caused its production.

ANTI-DEPRESSANT Popular term for various groups of drugs used in treating depressions. Not to be confused with tranquilizers or ataractics.

ANXIETY Apprehension, tension or uneasiness which stems from the anticipation of danger, the source of which is largely unknown or unrecognized. Primarily of intrapsychic origin, in distinction to fear, which is the emotional response to a consciously recognized and usually external threat or danger. Anxiety and fear are accompanied by similar physiologic changes. May be regarded as pathologic when present to such extent as to interfere with effectiveness in living, achievement of desired goals or satisfactions, or reasonable emotional comfort.

APHASIA Loss of ability to speak, occurring as the result of a cerebrovascular accident, brain tumor, or injury to the speech centers of the brain. It may also result from an emotional disturbance.

APNEA A temporary absence of breathing. It is characteristic of Cheyne-Stokes respiration.

APOPLEXY Cerebrovascular accident.

APPENDICITIS Acute or chronic inflammation of the appendix.

APPROXIMATION Nearly correct or exact; to approach or come close; used in behavior-shaping to refer to behavior which is close to what the trainer wants.

ARTERIOSCLEROSIS Hardening of the arteries due to formation of fibrous tissue, causing the blood vessels to lose their elasticity.

ARTICULATION DEFECT A speech problem characterized by difficulty in forming various speech sounds.

ASCHHEIM-ZONDEK TEST Pregnancy test in which urine is injected into mice.

ASCITES Accumulation of fluid in the abdominal cavity. It occurs in patients with congestive heart disease and some types of kidney disease.

ASPHYXIA Suffocation due to decrease of oxygen and increase of carbon dioxide in the body.

ASSOCIATION Relationship between ideas or emotions by contiguity, continuity, or by similarities.

ASTIGMATISM A defect in the curvature of the cornea of the eye so that all light rays do not bend equally as they enter the eye.

ASYMMETRICAL TONIC NECK REFLEX When a person is lying down and head is turned to one side, the arm (and perhaps leg) extend on the face side and contracts (flexes) on the opposite side; normal until six months of age.

ATAXIA A lack of coordination in motor movements, occurring in persons with nervous system syphilis and cerebral palsy.

ATELECTASIS A collapse of a portion or all of the lung due to disease, injury, or as a therapeutic procedure. It may also be spontaneous without known cause.

ATHEROSCLEROSIS A degenerative process characterized by the formation of fatlike deposits (plaques) along the walls of the arteries. It is believed due to some disturbance of fat metabolism.

ATHETOID A type of cerebral palsy in which involuntary movements are present in one or more parts of the body.

ATTENDANT Used in this manual to refer to all pre-professional employees who work on the ward, cottage, or dormitory, in residential institutions for the mentally retarded; these employees are sometimes referred to as cottage parents, matrons, psychiatric aides, or nurses aides; they may be at basic classification or may be building supervisors.

ATTENTION SPAN The length of time a person can concentrate on one thing or engage in one activity before losing interest.

ATTITUDES The biases, feelings, and opinions which one has toward situations, people, and objects.

ATYPICAL CHILD Nonspecific term for a child with distorted personality development. Applied most often to autistic children with perceptual handicaps and brain damage.

AUDITORY Relating to hearing; auditory discrimination refers to an ability to distinguish one sound from another.

AURA A visual sensation experience by the epileptic just prior to seizure.

AUTISM (AUTISTIC THINKING) A form of thinking which gratifies unfulfilled desires without regard for reality. Objective facts are distorted, obscured, or excluded in varying degree.

AUTONOMIC NERVOUS SYSTEM That part of the nervous system ordinarily not subject to voluntary control. It operates outside of consciousness and controls basic life preserving functions such as the heart rate and breathing.

BASAL METABOLISM A breathing test to determine the amount of oxygen consumed by the body in a fasting state and at rest. The test is used in the diagnosis of disease of the thyroid.

BEHAVIOR Whatever is done by a living organism; most authorities include thinking as a form of behavior.

BELL'S PALSY (BELL'S PARALYSIS) A facial paralysis that generally occurs on one side of the face only and may be associated with trigeminal neuralgia.

BILIARY Term applying to the gallbladder, liver, and their ducts.

BILIARY COLIC Acute pain in the upper abdomen caused by an obstruction of the cystic duct and usually due to a stone.

BLEPHARITIS A disease affecting the eyelids, causing redness and small scales on the margin of the lids.

BODY ALIGNMENT The proper positioning of the body parts so that undue strain is not put on any one part and deformities are prevented.

BRADYCARDIA A cardiac arrhythmia marked by an unusually slow heartbeat.

BRAIN SYNDROME An organic psychiatric disorder characterized by impairment of orientation, memory, intellectual functions and judgment, together with emotional instability. The disability may be due to such factors as injury, aging, toxins, infections, or tumors. May be acute or chronic, reversible or irreversible.

BRIGHT'S DISEASE A general term used synonymously with nephritis, a disease of the kidneys.

BRONCHIECTASIS A chronic disease of the lungs in which there is a dilation of the bronchi. It may affect both lungs or only a portion of one lung.

BURSITIS Acute chronic inflammation of a bursa that may be caused by injury or infection or may be of unknown cause.

CARBUNCLE A boil with infiltration into adjacent tissues, finally opening in several places on the skin. It is of staphylococcal origin and frequently occurs on the back of the neck.

CARDIOGRAM A tracing of the electrical activity of the heart, but only the electrical potential is transmitted to the skin. It is valuable in the diagnosis of certain heart disorders.

CARDIOSPASM A spasm of the cardiac valve between the esophagus and the stomach. It is generally a functional disorder.

CARRIER A person who harbors the germs of a disease and transmits the disease to others, while remaining well himself.

CASTRATION In psychiatry, usually the fantasied loss of the penis. Also used figuratively to denote state of impotence, powerlessness, helplessness, or defeat, etc.

CATHARSIS (1) The healthful (therapeutic) release of ideas through a "talking out" of conscious material accompanied by the appropriate emotional reaction. (2) The release into awareness of repressed (i.e., "forgotten") material from the unconscious. Catharsis and abreaction are sometimes incorrectly used interchangeably.

CAUDAL BLOCK (CAUDAL ANASTHESIA) A type of regional anesthesia induced by injecting a solution into the caudal canal. It is used to anesthetize tissues of the cervical, vaginal, and perineal areas.

CEREBRAL DOMINANCE The natural tendency for one side of the brain (hemisphere) to control certain behaviors.

CEREBRAL PALSY A neuromuscular disease affecting motor coordination and characterized by spasticity and involuntary movements.

CEREBROVASCULAR ACCIDENT Same as apoplexy or stroke. Results from damage to brain tissue.

CHANCRE The lesion of primary syphilis occurring at the point of inoculation by the Treponema pallidum.

CHARACTER DISORDER A syndrome characterized by unhealthy patterns of behavior and emotional responses such as acting out which are to varying degrees socially unacceptable or disapproved. There is usually very little evidence of anxiety or symptoms as ordinarly seen in the neuroses. The symptoms are ego-syntonic. Approximates concept of character neurosis.

CHARACTER NEUROSIS Similar to character disorder except that the neurotic conflicts are expressed in exaggerated but socially acceptable patterns of behavior and may not be easily recognizable as symptoms.

CHEYNE-STOKES RESPIRATION A type of breathing in which the depth and rhythm vary but a fairly consistent pattern is followed. It is often seen in critically ill patients.

CHOLECYSTITIS Inflammation of the gallbladder, which may cause various vague symptoms.

CHOLELITHIAS Calculi in the gallbladder. A stone may obstruct one of the ducts, causing an acute attack of biliary colic.

CHOLESTEROL A substance present in all body tissues and fluids and may be increased in certain diseases. It is thought to be a factor in the development of atherosclerosis.

CHROMOSOME The parts of a cell which carry the genes (hereditary factors).

CHRONOLOGICAL AGE The life age or actual age of an individual.

CLEFT PALATE An opening in the roof of the mouth.

CLIMACTERIC Synonymous with menopause; the age at which menstruation ends and the childbearing period ceases.

COLECTOMY The surgical removal of all or part of the colon because of ulcerative colitis or cancer.

COLOSTOMY A surgical procedure for the purpose of providing an artificial passageway for fecal material from the colon to the outside of the abdomen.

COMMITMENT In psychiatry, the legal process for the mandatory hospitalization of an individual in need of treatment for a mental disorder. To be distinguished from medical, informal, voluntary, and other forms of admission to a hospital.

COMMUNITY MENTAL HEALTH CENTER A community-based facility, or a complex of such facilities, for the prevention and treatment of mental illness. May include a full spectrum of services such as inpatient, outpatient, day hospital, night hospital, emergency, aftercare, rehabilitation, public education, consultation, and evaluation services.

COMMUNITY PSYCHIATRY A broad and relatively recent term referring to the use of all available forces, resources and techniques that facilitate the treatment of the psychiatric patient in his own community.

COMPENSATION (1) A defense mechanism, operating unconsciously, by which the individual attempts to make up for real or fancied deficiencies. (2) A conscious process in which the individual strives to make up for real or imagined defects in such areas as physique, performance, skills, or psychological attributes. The two types frequently merge.

COMPULSION An insistent, repetitive, intrusive, and unwanted urge to perform an act which is contrary to the person's ordinary conscious wishes or standards. A defensive substitute for hidden and still more unacceptable ideas and wishes. Failure to perform the compulsive act results in overt anxiety.

CONCEPT An abstract idea developed or generalized from particular examples or instances.

CONFLICT The clash, largely determined by unconscious factors, between two opposing emotional forces. For example, an instinctual wish for gratification may conflict with restrictions of conscience (intrapsychic conflict), or with external social requirements. Conflict is basic in psychic life and fundamental in the etiology of psychological disorders.

CONGENITAL Present at the time of birth; usually refers to a physical abnormality.

CONIZATION A surgical procedure in which a cone-shaped portion of tissue is removed from the cervix.

CONTUSION A bruise or black and blue spot due to injury causing the rupture of small blood vessels.

CONVERSION A mental mechanism, operating unconsciously, by which intrapsychic conflicts, which would otherwise give rise to anxiety, are instead given symbolic external expression. The repressed ideas or impulses, plus the psychologic defenses against them, are converted into a variety of somatic symptoms. Example: psychogenic paralysis of a limb which prevents its use for aggressive purposes.

CONVULSIVE DISORDER A condition in which a person has convulsions; involuntary series of muscular contractions due to a brain disorder.

COORDINATION To act together in a smooth way; several muscle groups working together in harmony.

CORPUSCLES Synonymous with red and white blood cells.

CORYZA An acute upper respiratory infection, a common cold.

CRANIOTOMY A surgical opening of the cranium for exploration or the removal of a tumor or blood clot.

CREDE'S METHOD A method by which external pressure in a downward direction is used to express urine from the bladder or to express the placenta following delivery.

CRETINISM Severe thyroid deficiency, usually accompanied by retardation and bodily malformations such as squat and fat stature, saddle-shaped nose, yellow skin and scanty dry hair. The condition is present at birth.

CRYPTORCHISM Undescended testicle, a condition in which the testicle may fail to descend into the scrotum prior to birth.

CULTURE The characteristic values and other features of behavior of a group, nation, or race of people.

CURETTAGE A surgical procedure in which a cavity is scraped with an instrument called a curet. It is frequently used as uterine curettage.

CURRICULUM The content or courses of training offered.

CUSTODIAL MENTALLY RETARDED Term formerly used to describe profoundly retarded.

CYANOSIS A bluish color of the skin resulting from obstruction of the airway or inadequate oxygenation of the blood.

CYBERNETICS Term introduced by Norbert Wiener (1894-1964) to designate the science of control mechanisms. It covers the entire field of communication and control in machines and puts forth the hypothesis that there is some similarity between the human nervous system and electronic control devices.

CYCLOTHYMIC PERSONALITY A personality characterized by alternating moods of elation and sadness with mood swings out of proportion to apparent stimuli. The moods result from internal causes rather than from external events. In severe form, manic-depressive psychosis.

CYSTECTOMY The surgical removal of all or part of the urinary bladder due to injury or disease. The ureters are transplanted elsewhere in the body or brought to the outside.

CYSTITIS Inflammation of the urinary bladder. It may be the result of catheterization or infection from other parts of the urinary system.

CYSTOCELE Protrusion of the bladder into the vagina. It is often due to injury at the time of delivery.

CYSTOSCOPY Examination of the urinary bladder with a lighted instrument called a cystoscope. The examination permits direct visualization of the lining of the bladder.

CYSTS Saclike tumors that are generally nonmalignant. They may contain fluid or cheeselike material. They may occur on the ovaries as ovarian cysts or on the skin as a wen.

DAY HOSPITAL A special facility or an arrangement within a hospital setting which enables the patient to come to the hospital for treatment during the day and return home at night.

DEBRIDEMENT The removal of infected or necrotic tissue from a wound.

DEFENSE MECHANISM Specific intrapsychic defensive processes, operating unconsciously, which are employed to seek relief from emotional conflict and freedom from anxiety. Conscious efforts are frequently made for the same reasons, but true defense mechanisms are out of awareness (unconscious).

DEGENERATION Breaking down or deterioration; usually of a steady or progressive nature.

DEHYDRATION The loss of fluids from the tissues that may occur when output exceeds intake or, in some cases, when there is excessive loss of water.

DELAYED SPEECH A lag in the development of spoken language; usually restricted to those cases due to retardation, emotional problems or lack of stimulating environment.

DELIRIUM A mental state characterized by disorientation and confusion. Anxiety, fear, illusions, or hallucinations may also be present. A delirious patient must be watched carefully.

DELUSION A false belief out of keeping with the individual's level of knowledge and his cultural group. The belief results from unconscious needs and is maintained against logical argument and despite objective contradictory evidence.

DEPRESSION Psychiatrically, a morbid sadness, dejection, or melancholy; to be differentiated from grief, which is realistic and proportionate to what has been lost. A depression may be a symptom of any psychiatric disorder or may constitute its principal manifestation. Neurotic depressions are differentiated from psychotic depressions in that they do not involve loss of capacity for reality testing. The major psychotic depressions include agitated depression, involutional psychosis, and the depressed phase of manic-depressive psychosis.

DEPRIVATION See environmental deprivation.

DESQUAMATION A scaling or flaking off of skin following certain communicable diseases. It is also characteristic of psoriasis.

DEVELOPMENT The process of maturing; gradual unfolding.

DEXTERITY Skill and ease in using the hands.

DIABETES MELLITIS A chronic disease resulting from failure of the islands of Langerhans in the pancreas to secrete insulin. Therefore, the patient cannot metabolize sugar.

DIALYSIS The process of separating or removing certain substances such as drugs from the blood or separating urinary constituents when the kidney fails to perform its normal function. The artificial kidney is a form of dialysis.

DIAPHORESIS Excessive sweating.

DIAPHRAGMATIC HERNIA The protrusion of an abdominal organ through the diaphragm into the thoracic cavity.

DIGITALIZATION The administration of digitalis in doses sufficient to achieve the maximum physiologic effect without producing toxic symptoms. The patient is then said to be digitalized and is placed on a maintenance dose.

DIURESIS Increased urinary output. It may follow the administration of a drug or the administration of intravenous fluids.

DNA (DESOXYRIBONUCLEIC ACID) One of the key chemicals governing life functions. Found in the cell nucleus. Essential constituent of the genes. Governs the manufacture of RNA and certain other proteins.

DROOL To let saliva dribble from the mouth.

DROPLET NUCLEI Minute particles containing pathogenic organisms that dry and remain suspended in the air and are carried wherever the air goes.

DWARFISM Midget; underdevelopment of body due to an undersecretion of the growth hormone from the anterior pituitary gland.

DYNAMIC Not fixed; marked by continuous activity or change; emotional forces which determine feelings and behavior.

DYSCRASIAS Diseases of the blood such as primary anemia and leukemia.

DYSMENORRHEA Painful menstruation.

DYSPHAGIA A condition in which swallowing is difficult or impossible due to a spasm of the esophagus or the disease.

DYSPNEA Shortness of breath or difficult, labored breathing.

ECCHYMOSIS A large amount of bleeding in the tissues that may result from contusion.

EDUCABLE MENTALLY RETARDED Education term used to describe retarded who can profit from academic education; mildly retarded—IQ generally from 50 to 75.

EGO In psychoanalytic theory, one of the three major divisions in the model of the psychic apparatus, the others being the id and superego. The ego represents the sum of certain mental mechanisms, such as

perception and memory, and specific defensive mechanisms. The ego serves to mediate between the demands of primitive instinctual drives (the id), of internalized parental and social prohibitions (the superego), and of reality. The compromises between these forces achieved by the ego tend to resolve intrapsychic conflict and serve an adaptive and executive function. As used in psychiatry, the term should not be confused with its common usage in the sense of "self-love" or "selfishness."

ELECTROENCEPHALOGRAM A graphic tracing of the brain waves, useful in the diagnosis of epilepsy.

ELECTROLYTES The salts of various minerals that are in solution in the body and must be kept in a constant state of balance.

ELOPE In hospital psychiatry, a term sometimes used for a patient who leaves a mental hospital without permission.

ELECTROSHOCK TREATMENT Use of electric current to produce unconsciousness and/or convulsive seizures. Most effective in treatment of depressive reactions. Introduced by Cerletti and Bini in 1938. Modifications are electronarcosis, producing narcoticlike states, and electrostimulation, which avoids convulsions.

EMBOLECTOMY The surgical removal of a blood clot from a vein.

EMBOLISM A foreign substance in the bloodstream such as a fragment from a blood clot or an air bubble.

EMOTION A feeling such as fear, grief, joy, love, etc.

EMPHYSEMA A chronic disease affecting the lungs in which the air sacs become overdistended with air. One or both lungs may be involved.

EMPYEMIA Purulent exudate in the pleural cavity. It may follow pneumonia or pleurisy.

ENDEMIC Continuous presence of a few cases of a certain disease in a given community.

ENTERITIS Inflammation of the intestines generally caused by ingestion of contaminated food. It is bacterial in nature and may result in gastroenteritis.

ENUCLEATION The surgical removal of the eye.

ENVIRONMENT The total social, cultural, and physical factors which surround and influence a person.

ENVIRONMENTAL DEPRIVATION Lack of environmental stimulation and opportunity for learning which are ordinarily provided young children.

EPIDEMIC Occurrence of a large number of cases of disease in a specific area at the same time.

EPIDIDYMITIS An inflammation of the epididymis often resulting from gonorrhea.

EPILEPSY A disorder characterized by periodic motor or sensory seizures or their equivalents, and sometimes accompanied by a loss of con-

sciousness, or by certain equivalent manifestations. May be idiopathic (no known organic cause) or symptomatic (due to organic lesions). Usually accompanied by abnormal electrical discharge as shown by E.E.G.

EPISPADIAS A congenital malformation in which the male urethra opens on the underside of the penis.

EPISTAXIS Nosebleed.

ERYTHEMA A redness of the skin resulting from a number of causes, including certain types of allergic reactions.

ERYTHROBLASTOSIS A congenital blood disease of the newborn in which there is a reaction of the Rh negative antibodies of the mother with the Rh-positive antibodies of the fetus.

ERYTHROCYTES Red blood cells.

ESTROGEN Term describing any of the substances secreted by the ovaries that are responsible for secondary sex characteristics, the menstrual function, and reproduction.

ETIOLOGY The cause of a disease or condition.

EVALUATION An appraisal or determination of intelligence, personality, or physical characteristics.

EVISCERATION Opening of the abdominal wound and the protrusion of the intestines. The term is also used for some types of radical surgery in which the pelvic organs, bladder, and adjacent structures are removed.

EXACERBATION Becoming worse or relapse. The opposite of remission.

EXCORIATION An abrasion or denuded area of the skin.

EXPERIENCE A broad term referring to all the activities, whether conscious or unconscious, which have occurred during the life of an individual.

EXPRESSIVE APHASIA Difficulty in speaking a language; difficulty in expression due to a brain disorder.

ENTENSOR THRUST REFLEX Uncontrolled extension (straightening) of the arms, legs, head and back upon stimulation or excitement.

EXTINCTION The elimination of behavior through lack of reward or through punishment (negative reinforcement).

EXTRASYSTOLE A form of cardiac arrhythmia in which there are heartbeats that occur sooner than normally expected. It is common in older people.

EXTRAPYRAMIDAL SYNDROME A pathological condition which may occur as a side effect of certain psychotropic drugs. Usually characterized by muscular rigidity, tremors, and sometimes peculiar involuntary movements or postures. Parkinson's disease is basically the same syndrome when caused by chronic lesions in the brain.

EXTREMITIES The arms and/or legs.

EXUDATE Pus containing dead phagocytes, bacteria, cells, and tissue fluid.

FECES Stool or bowel movement.

FETISH An inanimate object, such as an article of apparel, symbolically endowed with special meaning. Often necessary for completion of the sexual act.

FLATULENCE Accumulation of gas in the intestinal tract.

FLEXED (FLEXION) Inward bending of a joint.

FRIEDMAN'S TEST A pregnancy test using rabbits.

FUNCTIONAL ILLNESS An illness of emotional origin in which organic or structural changes are either absent or develop secondarily to prolonged emotional stress.

GAMMA GLOBULIN A protein substance obtained from human plasma. It is used in treating persons with infectious hepatitis and is given also with measles vaccine.

GAS GANGRENE A serious spore-forming infection caused by the gas bacillus. The infection occurs in compound fractures and penetrating types of wounds.

GASTRITIS Inflammation of the stomach, often caused from ingestion of contaminated food (food infection). It may be accompanied by enteritis.

GASTROSTOMY Surgically inserting a tube into the stomach for feeding.

GAVAGE Feeding by a tube inserted through the mouth or nose.

GENE Any of the parts of the chromosome which carry the hereditary characteristics.

GERONTOLOGY The branch of medicine concerned with the study, diagnosis, and treatment of diseases associated with the aging process.

GESTALT PSYCHOLOGY A German school of psychology which places emphasis on a total perceptual configuration and the interrelations of its component parts.

GIANTISM Excessive growth of long bones due to an oversecretion of the growth hormone from the anterior pituitary gland.

GLAUCOMA An eye disease caused by increased intraocular pressure that may result in blindness unless treated.

GLOMERULONEPHRITIS A type of nephritis (Bright's disease) in which the glomeruli of the kidney are involved.

GLYCOSURIA The presence of sugar in the urine.

GONADS Sex glands; testes in the male and ovaries in the female.

GRAVE'S DISEASE Exophthalmic goiter.

GYNECOLOGY The branch of medicine concerned with the diagnosis and treatment of diseases of the female reproductive system.

HALFWAY HOUSE In psychiatry, a specialized residence for mental patients who do not require full hospitalization but who need an intermediate degree of protection and support before returning to fully independent community living.

HEMATEMESIS The vomiting of blood. It may result from any condition in which blood is swallowed, or it may result from bleeding in the stomach.

HEMATOCRIT A laboratory examination of blood to measure the volume of red cells and the plasma.

HEMATURIA The presence of blood in the urine.

HEMIPLEGIA Paralysis affecting one side of the body as in cerebrovascular accident.

HEMOPTYSIS Hemorrhage that may be from the lungs, trachea, or larynx.

HEPATITIS Inflammation of the liver. Infectious hepatitis is caused by an unknown virus; serum hepatitis is caused by improper sterilization of syringes and needles or by blood transfusion.

HEREDITY The biological mechanism by which characteristics are passed on from parents to the offspring.

HERPES SIMPLEX Cold sore or fever blister. It is caused by a virus.

HERPES ZOSTER (ZOSTER OR SHINGLES) Disease caused by a virus that affects the nerve root in the thoracic region. A rash occurs on the skin following the peripheral nerve, usually the intercostal nerve.

HIRSUTISM Excessive growth of hair, particularly on the face in the female. The condition may be normal for some persons or may be due to disease.

HISTOPLASMOSIS A benign disease caused by a fungus. It often involves the lungs, causing calcified areas similar to tuberculosis.

HODGKIN'S DISEASE A highly fatal disease that involves the lymph nodes. The disease is classified with cancer.

HOSTILE Having ill will or ill feelings toward someone or something, may be conscious or unconscious.

HUHNER TEST A test to determine sterility in the male.

HYDRONEPHROSIS Distention of the kidney pelvis with urine due to an obstruction along the urinary route.

HYPERKINESIS Increased or excessive muscular activity seen in some neurological conditions, but more frequently in psychiatric disorders, especially in children.

HYPERTROPHY Enlargement of an organ that may or may not be due to disease.

HYPNOTIC A drug administered to produce sleep.

HYPOSPADIAS A congenital malformation of the male urethra.

HYPOSTATIC PNEUMONIA Pneumonia resulting from remaining in the same position for long periods of time.

HYPOTHERMIA An adjunct to anesthesia produced by lowering the body temperature below normal. It may be regional or general.

HYPOXIA A deficiency of oxygen in the tissues.

HYSTERIA An illness resulting from emotional conflict and generally characterized by immaturity, impulsiveness, attention-seeking, dependency, and the use of the defense mechanisms of conversion and dissociation. Classically manifested by dramatic physical symptoms involving the voluntary muscles or the organs of special senses.

ICTERUS INDEX A figure showing the amount of yellowness in the blood serum, found by comparative testing. Is useful in the diagnosis of jaundice.

IDENTIFICATION A defense mechanism, operating unconsciously, by which an individual endeavors to pattern himself after another. Identification plays a major role in the development of one's personality and specifically of one's superego, including the conscience. To be differentiated from imitation as a conscious process.

IDIOT Term once used to refer to profoundly retarded.

ILEOSTOMY A surgical procedure in which an artificial passage is constructed from the ileum to the outside of the abdomen.

IMBECILE Term once used to refer to the severely retarded.

IMPETIGO CONTAGIOSA A contagious skin disease occurring primarily in children.

INCONTINENCE Inability to retain urine in the bladder. Total incontinence exists when no urine can be held in the bladder.

INSOLENCE Haughty attitude; insulting; not respectful.

INSULIN COMA TREATMENT A form of treatment in which insulin is injected in large enough doses to produce profound hypoglycemia (low blood sugar) resulting in deep coma. First used by Manfred Sakel in 1933. Infrequently used in the United States since the advent of tranquilizers.

INTELLIGENCE A term used to describe a person's mental capacity; generally related to such things as problem-solving ability, ability to adapt to environment, or memory for learned material.

INTELLIGENCE QUOTIENT A numerical rating determined through psychological testing which indicates approximately the relationship of a person's mental age (MA) to his chronological age (CA).

INTRAVENOUS Within the veins.

INTUSSUSCEPTION A telescoping of the intestine that may involve any part of the small or large intestine. The condition occurs primarily in infants and very young children.

INVOLUTIONAL PSYCHOSIS A psychotic reaction occurring in late middle life. Formerly thought to be related to the menopause in the female and the climacteric in the male. Characterized most commonly by

depression and occasionally paranoid thinking. The course tends to be prolonged and the condition may be manifested by feelings of guilt, anxiety, agitation, severe insomnia, and somatic preoccupations, often of a delusional or nihilistic nature.

JARGON A state of speech development in infants characterized by unintelligible jumble of syllables.

JAUNDICE A yellow color affecting the skin and the sclera of the eyes caused by bile pigments in the blood.

KELOID A benign overgrowth of fibrous tissue about the size of a scar; is more common in the Negro.

KERATITIS Inflammation of the cornea of the eye with ulcer formation.

KERATOPLASTY Corneal transplant.

KETOSIS The presence of ketone or ketone bodies in the urine. It occurs in diabetic acidosis.

KOPLIK'S SPOTS White spots on reddened base that occur in the throat of persons with measles.

KYPHOSIS Curvature of the spine backward causing what is called humpback. It may be congenital or due to disease.

LACRIMAL FLUID Tears secreted by the lacrimal gland.

LAMINECTOMY A surgical procedure performed for a ruptured disc or for spinal fusion.

LANGUAGE A means of communicating ideas or feelings by the use of signs, vocal sounds (words) or gestures.

LAPARATOMY Any surgical procedure for which the abdomen is opened.

LARYNGECTOMY A surgical procedure for removal of the larynx.

LARYNX The upper part of the trachea or tube which leads to the lungs; contains the vocal cords.

LENTIGO Freckles.

LETHARGY Condition of being listless or lifeless.

LEUKEMIA A serious and fatal disease of the blood. It is often referred to as cancer of the blood.

LEUKOCYTOSIS Marked increase in the number of leukocytes, occurring sometimes in the presence of infection.

LEUKOPLAKIA A condition in which white spots form on the mucous membrane of the mouth and which may become malignant.

LEUKORRHEA A white or yellow vaginal discharge.

LIGATURE A suture used in surgery to ligate (tie) a blood vessel.

LOBECTOMY Surgical removal of a lobe of the lung.

LORDOSIS An abnormal inward curvature of the lumbar spine.

LYMPH A fluid consisting of waste materials and excess tissue fluid.

LYMPHOMAS Malignant types of tumors.

MAMMARY GLAND The breast.

MANIA A suffix denoting a pathological preoccupation with some desire, idea or activity; a morbid compulsion.

MASTECTOMY Surgical removal of the breast, which may be simple or radical.

MATURATION The process of maturing or developing mentally, physically, or emotionally.

MEDIASTINUM The space between the lungs containing the heart.

MENARCHE The first menstruation at the time of puberty.

MENINGITIS An infection and inflammation of the meninges covering the brain and spinal cord.

MENOPAUSE The climacteric or cessation of the menses marking the end of the childbearing period.

MENORRHAGIA Excessive menstrual flow either in quantity or duration.

MENTAL AGE Level of intellectual development compared in terms of chronological age.

MENTAL DISORDER Any psychiatric illness or disease included in the Standard Nomenclature of Diseases and Operations with the official approval of the American Medical Association. The same disorders are officially defined in the Diagnostic and Statistical Manual for Mental Disorders, published by the American Psychiatric Association (1952). Many of these disorders are described in this Glossary.

MENTAL HEALTH A state of being which is relative rather than absolute in which a person has effected a reasonably satisfactory integration of his instinctual drives. His integration is acceptable to himself and to his social milieu as reflected in his interpersonal relationships, his level of satisfaction in living, his actual achievement, his flexibility, and the level of maturity he has attained.

MENTAL RETARDATION Lacking in intelligence, from birth or childhood, to a degree that interferes with a reasonable adjustment in social performance. Emotional conflict often complicates the condition. The need for institutional treatment and care is proportional to the degree of impairment and the level of emotional adjustment. There are four degrees of severity: mild (IQ 50-70); moderate (IQ 35-49); severe (IQ 20-34); profound (IQ below 20).

MENTALLY DEFECTIVE Term sometimes used to mean mentally retarded or feebleminded.

METABOLISM The sum of all processes that go on within the body, including the breaking down and wearing out, and the regeneration and building up processes.

METASTASIS Refers to the spreading of cancer cells by the bloodstream or lymph channels to other parts of the body from a primary tumor.

METRORRHAGIA Bleeding between regular menstrual periods.

MICTURITION The function of urinating.

MIDLINE Extending toward the middle; head in midline refers to facing straight ahead.

MIGRAINE An unusual type of headache that generally occurs on one side only.

MILDLY MENTALLY RETARDED The least handicapped of the retarded, with IQ range of 50-75; formerly referred to as moron, high grade, or Level III.

MODERATELY MENTALLY RETARDED The general IQ range of 35-49; generally considered trainable.

MORON Term formerly applied to mildly mentally retarded.

MOTIVATION A stimulus to action; something (a need or desire) that causes one to act.

MOTOR Movement of muscles.

MYDRIATIC A drug that dilates the pupil of the eye.

MYOSITIS An inflammatory condition of a muscle.

MYXEDEMA Hypothyroidism in adults characterized by changes in physical appearance and resulting mental apathy.

NARES Nostrils. The openings of the nasal cavity.

NARCISSISM (NARCISM) From Narcissus, figure in Greek mythology who fell in love with his own reflected image. Self-love, as opposed to object-love (love of another person). In psychoanalytic theory, cathexis (investment) of the psychic representation of the self with libido (sexual interest and energy). Some degree of narcissism is considered healthy and normal; but an excess interferes with others. To be distinguished from egotism, which carries the connotation of self-centeredness, selfishness, and conceit. Egotism is but one expression of narcissism.

NECROSIS The death of tissue. When large areas are involved such as an extremity, the condition is called gangrene.

NEOBLADDER A urinary bladder constructed from a portion of the sigmoid colon.

NEPHRECTOMY The surgical removal of a kidney.

NEPHRITIS Inflammation of the kidneys, which may be acute or chronic.

NERVOUS SYSTEM The system made up of the brain and spinal cord, nerves and parts of the sense organs.

NEVUS A congenital pigmented area of various types. Some nevi are moles; others, such as the spider angioma, occur in association with disease of the liver.

NIGHT HOSPITAL A hospital, or hospital service, for psychiatric patients who are able to work in the community during the day but who require specialized treatment and supervision in a hospital after working hours.

NON-AMBULATORY Not walking; unable to walk.

NUTRITION The processes involved in the growth and maintenance of the organism.

NYSTAGMUS A continuous movement of the eyeball. It may be associated with labyrinthitis.

OBJECT RELATIONSHIP The emotional bonds that exist between an individual and another person as opposed to his interest in, and love for himself; usually described in terms of his capacity for loving and reacting appropriately to others.

OBESE More than 10 percent above an average normal weight for age, height, and build.

OBSERVATION That which is seen or noticed.

OBSESSIVE PERSONALITY A type of character structure in which there is a pattern of several of the obsessive groups of personality traits or defenses, such as excessive self-imposed orderliness, worry over trifles, indecisiveness, and perfectionism. These may or may not be sufficiently marked to interfere with living, or to limit normal satisfactions and social adjustment.

OCCIPUT The protruding back part of the head or the back part of the head at the base of the skull.

OCCUPATIONAL THERAPY Treatment prescribed by a physician to improve physical or mental conditions enabling the patient to become a better functioning member of society; many media are used.

OCCUPATIONAL PSYCHIATRY A special interest field concerned with the diagnosis and prevention of mental illness in industry and with psychiatric aspects of absenteeism, accident proneness, personnel policies, operational fatigue, vocational adjustment, retirement, and related factors.

ONANISM Incomplete sexual relations with withdrawal just prior to emission. Coitus interruptus. Incorrectly used as a synonym for masturbation.

OOPHORECTOMY The surgical removal of an ovary.

OPACITY Omitting light or being opaque to light rays.

ORAL Having to do with or affecting the mouth, as in language.

ORCHITIS An inflammatory condition of the testes that may result from infection, injury, or a malignant condition.

ORGANIC Refers to the body, to the physical rather than to the psychological or behavioral.

ORGANIC DISEASE Characterized by significant demonstrable structural or biochemical abnormality in an organ or tissues. Sometimes imprecisely used as an antonym for functional illness.

ORTHOPSYCHIATRY Literally, corrective psychiatry. An approach to the study and treatment of human behavior which involves the collaborative

effort of psychiatry, psychology, psychiatric social work, and other behavioral, medical and social sciences in the study and treatment of human behavior in the clinical setting. Emphasis is placed on preventive techniques to promote healthy emotional growth and development.

OSTEOARTHRITIS A degenerative type of arthritis characteristic of the aging process.

OSTEOMYELITIS Infection and inflammation of the bone.

OSTEOPOROSIS A chromic disorder due to demineralization or absorption of minerals from the bone. It may be caused by prolonged immobilization and is common in aged persons.

OTITIS MEDIA An abscess in the middle ear, generally a complication from disease of the upper respiratory system.

OTOSCLEROSIS A disease in which changes in the bone occur so that the stapes in the middle ear cannot transmit sounds to the inner ear. The condition results in progressive deafness.

OVULATION The discharge of a mature ovum from the ovarian follicle.

PANDEMIC A disease that is widespread in a given area or throughout the world.

PAPANICOLAOU SMEAR TEST A cytologic test for detection of cancer cells.

PARANOIA Rare psychotic disorder which develops slowly and becomes chronic. It is characterized by an intricate and internally logical system of persecutory and/or grandiose delusions. The system stands by itself and does not interfere with the remainder of the personality, which continues apparently intact. To be distinguished from paranoid schizophrenic reaction and paranoid state.

PARAPLEGIA Paralysis of the lower part of the body below a point of injury to the spinal cord.

PAROLE (PAROLEE) In psychiatry, technical term for the conditional release of a patient from a mental hospital prior to formal discharge so that the patient may be returned to the hospital if necessary without legal action. Obsolescent because of its association with parole from prison. Similar in meaning to "trial visit," "on leave," and "home leave."

PAROXYSM Spasmodic attacks that recur at periodic intervals.

PASSIVE Submissive; controlled from the outside.

PASSIVE-AGGRESSIVE PERSONALITY Characterized by aggressive behavior exhibited in passive ways, such as pouting, stubbornness, procrastination, and obstructionism. May be considered a character disorder.

PASTORAL COUNSELING The use of psychological principles by clergymen in interviews with parishioners who seek help with emotional problems.

PERCEPTION The mental mechanism by which the nature and/or the meaning of a sensory stimulus or aggregate of stimuli is recognized.

It occurs through the use of the senses to integrate and interpret past experiences in response to a present stimulus.

PERSEVERATION Involuntary and pathological persistence of single response or idea in reply to various questions. Seen most often in organic brain disease.

PERSONALITY A broad term which refers to all of the traits or characteristics which make one individual different from another; the total behavior pattern of an individual.

PERSONALITY DISORDER A generic term denoting those mental conditions in which the basic disorder lies in the personality of the individual. There is minimal subjective anxiety and little or no sense of distress. For example, the terms passive-aggressive personality and compulsive personality fall into this category.

PERTUSSIS Whooping cough.

PESSARY A device used to support the uterus in a normal position.

PETECHIAE Small, pinpoint hemorrhagic spots on the skin that occur in some severe debilitating diseases.

PHAGOCYTOSIS The process by which phagocytes ingest and digest bacteria at the site of infection. It is characterized by an increase in the white blood cells.

PHARYNX The part of the throat located between the back of the mouth and the esophagus (tube leading to the stomach).

PHENOTHIAZINE A chemical originally used as a vermifuge. In psychiatry, a term applied to a group of tranquilizers which resemble phenothiazine in molecular structure.

PHENYLKETONURIA A metabolic disease which is genetically transmitted; the digestion of protein is disturbed and a substance is produced which causes developmental and other difficulties.

PHENYLPYRUVIC OLIGOPHRENIA A congenital metabolic disturbance characterized by an inability to convey phenylalanine to tyrosine. Results in abnormal chemicals which interfere with brain development. Transmitted genetically and treatable by diet when detected in infancy by testing the urine for the presence of phenylpyruvic acid. If untreated, mental retardation results. Also known as phenylketonuria.

PHIMOSIS A narrowing of the prepuce opening so that the foreskin cannot be retracted. Circumcision may be necessary.

PHLEBOTOMY Venesection; withdrawing blood from a vein.

PHOBIA An obsessive, persistent, unrealistic fear of an external object or situation. The fear is believed to arise through a process of displacing an internal (inconscious) conflict to an external object symbolically related to the conflict.

PHYSIOTHERAPY Treatment prescribed by physician for physical conditions, using heat, cold, massage, exercise, and other means to enable the patient to achieve better body function.

PRURITIS Extreme itching of the skin.

PSORIASIS A chronic skin disease of unknown cause, characterized by scaly patches and desquamation.

PSYCHIATRY The medical science which deals with the origin, diagnosis, prevention, and treatment of mental and emotional disorders. It also includes such special fields as mental retardation, the emotional components of physical disorders, mental hospital administration, and the legal aspects of psychiatric disorders.

PSYCHOANALYSIS A psychologic theory of human development and behavior, a method of research, and a system of psychotherapy, originally described by Sigmund Freud. Through analysis of free associations and interpretation of dreams, emotions and behavior are traced to the influence of repressed instinctual drives and defenses against them in the unconscious. Psychoanalytic treatment seeks to eliminate or diminish the undesirable effects of unconscious conflicts by making the patient aware of their existence, origin, and inappropriate expression in current emotions and behavior.

PSYCHODYNAMICS The systematized knowledge and theory of human behavior and its motivation, the study of which depends largely upon the functional significance of emotion. Psychodynamics recognizes the role of unconscious motivation in human behavior. It is a predictive science, based on the assumption that a person's total make-up and probable reactions at any given moment are the product of past interactions between his specific genic endowment and the environment in which he has lived from conception onward.

PSYCHOLOGY An academic discipline, a profession, and a science dealing with the study of mental processes and behavior in man and animal. Not to be confused with the medical specialty of psychiatry.

PSYCHONEUROSIS (PSYCHONEUROTIC DISORDER) Emotional maladaptations due to unresolved unconscious conflicts. One of the two major categories of emotional illness, the other being the psychoses. A neurosis is usually less severe than a psychosis, with minimal loss of contact with reality. Thinking and judgment may be impaired. A neurotic illness represents the attempted resolution of unconscious emotional conflicts in a manner that handicaps the effectiveness of a person in living. Types of neuroses are usually classified according to the particular symptoms which predominate.

PSYCHOPHYSIOLOGIC DISORDERS A term first used in the 1952 Diagnostic and Statistical Manual of Mental Disorders to replace the term "psychosomatic disorders." Refers to serious disturbances of any organ system caused by prolonged, unresolved emotional conflict.

PSYCHOSEXUAL DEVELOPMENT The changes and stages which characterize the development of the psychological aspects of sexuality during the period from birth to adult life.

PSYCHOSIS A major mental disorder of organic and/or emotional origin in which there is a departure from normal patterns of thinking, feeling, and acting. Commonly characterized by loss of contact with reality, distortion of perception, regressive behavior and attitudes, diminished control of elementary impulses and desires, abnormal mental content

including delusions and hallucination. Chronic and generalized personality deterioration may occur. A majority of patients in public mental hospitals are psychotic.

PSYCHOSOMATIC Adjective to denote the constant and inseparable interaction of the psyche (mind) and the soma (body). Most commonly used to refer to illnesses in which the manifestations are primarily physical with at least a partial emotional etiology.

PTOSIS A dropping from the normal position such as ptosis of the eyelid in facial paralysis.

PUBERTY Period of becoming sexually mature.

PUSTULE An elevated skin lesion containing pus.

PYELITIS An inflammatory condition of the kidney pelvis.

PYELONEPHRITIS An inflammation of the kidney pelvis with extension into the kidney tissue.

PYOGENIC Pus-producing.

QUADRIPLEGIA Paralysis of all four extremities.

RAPPORT In psychiatry, the conscious feeling of harmonious accord, mutual responsiveness and sympathy that contributes to the patient's confidence in the therapist and willingness to work cooperatively with him. To be distinguished from transference which is unconscious.

RECEPTIVE APHASIA Difficulty in understanding spoken or written language—due to brain disorder.

REFLEX An habitual way of responding; ordinarily refers to inborn tendency for a part of the body to respond to a stimulus in a certain way.

REHABILITATION Restoration of a skill or restoration of efficiency to a level that permits partial or complete vocational and social independence; frequently used with the mentally retarded to mean the same as habilitation.

REGRESSION The partial or symbolic return under conditions of relaxation or stress to more infantile patterns of reacting. Manifested in a wide variety of circumstances such as normal sleep, play, severe physical illness, and in many psychiatric disorders.

REGURGITATION Term usually applied to the return of food or fluids from the stomach. It may be the result of a functional disorder.

REINFORCEMENT Something which reinforces or makes stronger; usually refers to a reward which makes a habit stronger or better learned.

REMISSION Relief from symptoms or temporary improvement, the opposite of exacerbation.

REPRESSION A defense mechanism, operating unconsciously, which banishes unacceptable ideas, affects, or impulses, from consciousness or which keeps out of consciousness what has never been conscious. Although not subject to voluntary recall, the repressed material may

emerge in disguised form. Sometimes used as a generic term for all defense mechanisms. Often confused with the conscious mechanism of suppression.

RESIDENT Used in this manual to refer to the mentally retarded who live in a residential institution; frequently they are referred to as patients or students.

RESIDUAL Refers to a part remaining, as urine remaining in the bladder after voiding.

ROMBERG'S SIGN The inability to maintain balance with the eyes closed and the feet placed close together.

RUBELLA Measles.

RUBIN TEST A test to determine the patency of the fallopian tubes.

SCALE A graded series of questions or performances to rate an individual in such areas as personality, social maturity, achievement, and intelligence.

SCHIZOPHRENIA A severe emotional disorder of psychotic depth characteristically marked by a retreat from reality with delusion formation, hallucinations, emotional disharmony, and regressive behavior. Formerly called dementia praecox.

SEBACEOUS GLANDS Oil glands that secrete sebum.

SEBORRHEA An increased secretion of sebum from the sebaceous glands.

SECONDARY Dependent upon that which is considered a primary cause; second in order of development.

SECONDARY DRIVE A drive or motive which is learned rather than natural or inborn.

SEIZURE An attack of disease—usually refers to convulsion or epileptic attacks.

SELF-CARE SKILL The ability to care for oneself; usually refers to basic habits of dressing, eating, etc.

SENILITY Old age with physical and mental changes.

SENSATION A feeling produced by stimulation of sense organs, such as seeing, hearing, etc.

SENSORIUM Roughly synonymous with consciousness. Includes the special sensory perceptive powers and their central correlation and integration in the brain. A clear sensorium conveys the presence of a reasonably accurate memory together with correct orientation for time, place, and person.

SENSORY Pertaining to sensation.

SEPARATION ANXIETY The fear and apprehension noted in infants when removed from their mothers (or surrogates) or in being approached by strangers. Most marked from 6th to 10th month. In later life, similar reaction may result from removal of significant persons or familiar surroundings.

SEPTICEMIA A bloodstream infection resulting from invasion of the blood by bacteria or their toxins.

SEVERELY MENTALLY RETARDED The general IQ range of 20 to 34; those who fall between the profoundly retarded and moderately retarded.

SEQUENCE A series of behaviors; a set of related elements; used in training to refer to a part of a skill or habit which is taught and later linked with other parts of the habit.

SEXUAL DEVIATION Sexual behavior at variance with more or less culturally accepted sexual activities. Includes homosexuality, transvestitism, sexual sadism, and sexually violent (criminal) acts.

SHAPING BEHAVIOR Teaching an individual to behave in a certain way; used here to refer to training by use of rewards (positive reinforcement) to correct responses or behavior.

SHELTERED WORKSHOP A facility (usually in the community) which provides occupational training and/or protective employment for handicapped persons.

SIGMOID The part of the lower colon connecting with the anal canal.

SOCIOPATH A recent term now in general use and essentially the same as psychopathic personality but also connoting a pathological attitude toward society.

SODOMY Anal intercourse between males. Legally, the term may include other types of perversion such as bestiality.

SORDES A foul accumulation of secretions and crusts about the teeth and mouth caused by lack of mouth care during severe illness such as fevers.

SPASM A severe muscle contraction.

SPASTIC (SPASTICITY) A type of cerebral palsy in which there is limited motion primarily in bending (flexor) muscles when the limb is straightened.

SPHINCTER Muscle that is circular in shape and constricts an anatomic opening, such as the rectal sphincter.

SPINA BIFIDA An opening in the vertebral column with the covering of the spinal cord (meninges) protruding . . . a developmental defect present at birth.

SPONTANEOUS Unplanned; natural; impulsive.

STASIS A slowing or stopping of normal flow.

STEROIDS A term applied to the cortisone secretions of the adrenal cortex.

STIMULUS That which causes a response.

STOMA The opening onto the skin created by an artificial passageway or normal opening such as a pore.

STRABISMUS Cross-eye.

STUTTERING A speech problem marked by a disturbance in the rhythm of

speech; the speech may consist of repetition of syllables or periods of blocking or halting speech.

SUPEREGO In psychoanalytic theory, that part of the personality associated with ethics, standards and self-criticism. It is formed by the infant's identification with important and esteemed persons in his early life, particularly parents. The supposed or actual wishes of these significant persons are taken over as part of the child's own personal standards to help form the "conscience." In later life they may become anachronistic and self-punitive, especially in psychoneurotic persons.

SUPPORTIVE PSYCHOTHERAPY A technique of psychotherapy which aims to reinforce a patient's defenses and to help him suppress disturbing psychological material. Supportive psychotherapy utilizes such measures as inspiration, reassurance, suggestion, persuasion, counseling, and reeducation. It avoids probing the patient's emotional conflicts in depth. It is the treatment of choice for patients too fragile to achieve insight or whose symptoms are not sufficient to warrant intensive psychotherapy.

SYMPTOM A specific manifestation of a patient's condition indicative of an abnormal physical or mental state. Psychiatric symptoms are often the result of unconscious conflict and may represent in symbolic form an instinctual wish, the defense against such a wish, or a compromise between the two.

SYNDROME A configuration of symptoms which occur together and which constitute a recognizable illness. Example: Ganser's syndrome.

TACHYCARDIA A cardiac arrhythmia that results in a very rapid heartbeat.

TENACIOUS A descriptive term frequently applied to respiratory secretions that are sticky, stringy, and tend to hold together, making expectoration difficult.

TENSION ATHETOSIS A type of cerebral palsy marked by stiffness in the limbs usually in extensor position.

TETANY A paroxysmal type of spasm involving the extremities.

THERAPEUTIC COMMUNITY A term of British origin, now widely used, for a specially structured mental hospital milieu which encourages the patient to function within the range of social norms. Special educational techniques are used to overcome the patient's dependency needs and to encourage him to assume personal responsibility to speed the social rehabilitation of himself and the group.

THERAPY Treatment.

THORACOTOMY A surgical opening into the thoracic cavity.

THROMBOSIS The presense of a blood clot.

THRUSH An infection of the mouth and throat caused by a fungus, generally occurring in infants.

TIC An intermittent, involuntary, spasmodic movement such as a muscular twitch, often without demonstrable external stimulus. A tic may be a

disguised expression of a hidden emotional conflict or the result of neurologic disease.

TOPICAL External or local.

TOXIN A poisonous substance produced by certain bacteria.

TRACHEOTOMY A surgical opening into the trachea to provide a patient airway.

TRAINABLE MENTALLY RETARDED Education term used to describe those in the general IQ range of 30 to 49 who benefit from training mainly in the self-care and social areas rather than in academic subjects.

TRANSFERENCE The unconscious "transfer" to others of feelings and attitudes which were originally associated with important figures (parents, siblings, etc.) in one's early life. The transference relationship follows roughly the pattern of its prototype. The psychiatrist utilizes this phenomenon as a therapeutic tool to help the patient understand his emotional problems and their origin. In the patient-physician relationship the transference may be negative (hostile) or positive (affectionate).

UNCONSCIOUS In Freudian theory, that part of the mind or mental functioning the content of which is only rarely subject to awareness. It is repository for data which have never been conscious (primary repression), or which may have become conscious briefly and was then repressed (secondary repression).

UREMIA Accumulation of urinary constituents in the blood stream because of kidney failure. A generalized toxic condition results.

URTICARIA (Hives) An allergic reaction characterized by the appearance of wheals on the skin.

VACCINE A pathogen whose virulence has been reduced and which is used as prophylaxis against a disease.

VENTRICULOGRAM A procedure in which air is injected into the cerebral ventricles and x-ray films are taken.

VENULES The smallest blood veins.

VERTIGO A sensation characterized by the movement of objects or of extreme dizziness and a feeling of self-movement.

VIRAL Pertaining to infections caused by a virus.

VIRULENCE The strength of an organism in producing disease.

VITAL CAPACITY The capacity of the lungs to hold air as measured by the expired air following a full inspiration.

VOCAL FOLDS The vocal cords; folds of mucous membranes that stick out into the cavity of the larynx. When they are tightened and air is blown through them sound is produced.

VOICE DISORDERS A defect in the quality or tone of the voice such as high pitched or hoarse.

VOYEURISM Sexually motivated and often compulsive interest in watching or looking at others, particularly at genitals. Roughly synonymous with "peeping Tom." Observed predominantly in males.

W.A.I.S. (WECHSLER ADULT INTELLIGENCE SCALE) A verbal and performance test especially designed to measure intelligence in adults.

WANGENSTEIN SUCTION A suction siphonage method to remove secretions from the stomach.

WEN A cyst generally occurring on the back of the head.

WHEAL An elevated type of skin rash caused by an allergic reaction, frequently from bites or stings from insects.

WILMS'S TUMOR A malignant tumor of the kidney occurring in children under 5 years of age.

WITHDRAWAL In psychiatry, a pathological retreat from people or the world of reality, often seen in schizophrenics.

WORKING RESIDENTS Less severely retarded residents who have jobs (such as housekeeping and taking care of the more severely retarded) in the institution; sometimes referred to as working boy or working girl.

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A small volume in which the author lists various experiences familiar to all chaplains and examines the experience and his reactions. Again, while worthwhile for the chaplain, this book will be especially valuable for the Chaplain Supervisor as a working draft of theological reflection upon pastoral experience.

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In trying to explain the chaplain's unique role within the professional healing team, Faber draws upon the at-first peculiar, but ultimately helpful figure of the Chaplain as the clown. The role of a clown in the circus and a chaplain in the hospital are analogous —humanization. Although written from a European context, this book can provide a valuable insight to the chaplain, to the chaplain-intern, as well as to other health professionals.

COMMON INITIALS AND ABBREVIATIONS

a before
abd. abdominal
abort. or A.B. abortion
A.B.R. absolute bed rest
a.c. before meals
ADL activities of daily living
accom. accommodation
ad lib. as desired
adm. admission
alb. albumin
amp. ampule
Aort. regurg. aortic regurgitation
Aort. sten. aortic stenosis
A-P, a&p anterior and posterior, front and back
ASHD arterioscleratic heart disease
Aur. fib. auricular fibrillation, convulsive movements of the auricles of the heart
AV arteriovenous, pertaining to an artery and a vein

BBB bundle bronch block
BBT bosol body temperature
B.E. barium enema
b.i.d. twice a day
b.m. bowel movement
B.M.R. basal metabolism rate
B.P. blood pressure
B.R.P. bathroom privileges
B.S.P. bromsulphalein, liver function test
B.T. bedtime
B.U.N. blood urea nitrogen

c with
CA chronological age
ca. carcinoma, cancer
cath. catheterized or catheter
C.B.C. or c.b.c. complete blood count
C.B.I. continuous bladder irrigation
C.B.R. complete bed rest
CBS chronic brain syndrome
C.C. chief complaint
C.C.U. coronary care unit
C.H.D. congenital heart disease
CHF congestive heart failure
cm. centimeter

C.N.S. central nervous system
CO_2 carbon dioxide
CP cerebral palsy
CPR cardiopulmonary resuscitation
C.S.F. cerebrospinal fluid
C.S.R. central supply room
Cta. catamenia, menses
C.V.A. cerebrovascular accident (stroke)
C.V.D. cardiovascular disease
Cysto. cystoscopic examination

D. & C. dilatation and curettage
D.L. danger list
D.M. diastolic murmur
D.O.A. dead on arrival
d.o. right eye
D.P.C. Department of Pastoral Care
DT's delirium tremens
Dx diagnosis

E.C.G. or E.K.G. electrocardiogram
E.C.T. electroconvulsive therapy
E.D.C. expected date of confinement
E.E.G. electroencephalogram
E.E.N.T. eye, ear, nose and throat
E.N.T. ear, nose, throat
E.R. emergency room
EST electric shock therapy
et and

FACP Fellow American College of Physicians
FBS fasting blood sugar
FH family history
FHT fetal heart tone
fract. fracture
FS frozen section
F.U.O. fever of unknown origin

g.b. gallbladder
GC. gonococcus (gonorrhea)
G.I. gastrointestinal
Gm gram
G.P. general practitioner
gr. grain

gtt. drop
G.U. genitourinary
gyn gynecology

h hour
Hct. hematocrit
Hgb. Hemoglobin
HLR heart-lung resuscitation
h.s. bedtime
Hx history
I.C.U. intensive care unit
I & D incision & drainage
I.M. intramuscularly
I & O intake and output
iss one and one half
IST insulin shock therapy
I.V. intravenously
I.V.P. intravenous pyleogram—X-ray study

lab. laboratory
lap. laparotomy
lat. lateral
L.L.L. left lower lobe-lung
L.L.Q. left lower quadrant—abdomen
L.M.P. last menstrual period
L.P. lumbar puncture
L.P.N. licensed practical nurse
L.U.L. left upper lobe—lung
L.U.Q. left upper quadrant—abdomen
L. & W. or l. & w. living and well

m. married
MAS Taylor Manifest Anxiety Scale
mg. milligram
MH marital history
M.I. myocardial infarction
MMPI Minnesota Multiphosic Personality Inverty
M.P. menstrual period
M.S. multiple sclerosis; morphine sulfate; mitral stenosis

neg. negative
noct. nocturnal
N.P.N. nonprotein nitrogen
N.P.O. nothing by mouth

O_2 oxygen
OB. obstetrics
occ. occasional
o.d. everyday; right eye
OD overdose drugs
oint. ointment
O.P.D. outpatient department
O.R. operating room
os mouth
o.s. left eye
O.T. occupational therapy
O.U. both eyes, together

P_2 pulmonic second heart sound
PA pernicious anemia
PAC premature atrial contractions
palp. palpable
P.B.I. protein-bound iodine
p.c. after meals
P.D.R. physicians desk reference (drug formulary)
Ped. pediatrics
P.E.G. pneumoencephalogram
per by
P.H. past history
P.I. present illness
P.I.D. pelvic inflammatory disease
PMA Primary Mental Ability Test
P.M.D. private medical doctor
P.O. by mouth
p.o. phone orders
post op or p.o. post operative
prep. preparation
p.r.n. whenever necessary
PT. physical therapy
PVC. premature ventricular contractions
Px. physical examination

q. every
q.d. every day
q.h. every hour
q.2h. every two hours
q.i.d. four times a day
q.n. every night
q.n.s. quantity not sufficient
q.o.d. every other day
q.s. sufficient quantity

R.B.C. or r.b.c. red blood count; red blood cell
Rh. rhesus (monkey)
R.H.D. rheumatic heart disease
R.L.L. right lower lobe—lung
R.L.Q. right lower quadrant—abdomen
R.M.L. right middle lobe—lung
R.R.E. round, regular and equal
R.U.L. right upper lobe—lung

R.U.Q. right upper quadrant—abdomen
Rx take
Rx therapy

s without
sat. saturated
SAT School Ability Test
SB Stanford-Binet Test
S.C.B. strictly confined to bed
sed. sedimentation
Sig. signify
S.O.B. shortness of breath
S.O.S. whenever necessary, one dose only
spec. specimen
ss one-half
s.s. soap solution
Staph. staphylococcus
Stat. at once
Strep. streptococcus
Subcu subcutaneous

T. & A. tonsillectomy and adenoidectomy
T.A.T. tetanus antitoxin
TAT Themotic Apperception Test
tab. tablet
T.b. tubercle bacillus
Tbc. tuberculosis
t.i.d. three times daily
T.L.C. tender loving care
T.P.R. temperature, pulse, respiration
T.U.R. transurethral resection

ung. ointment
U.R.I. upper respiratory infection

Vag. vaginal
VD. venereal disease
VDRL venereal disease research laboratory

WAIS Wechsler Adult Intelligence Scale
W.B.C. or w.b.c. white blood count
w.d. well developed
WISC Wechsler Intelligence Scale for Children
w.n. well nourished

A. Diagnostic Suffixes
-cele
hernia, tumor, protrusion
-emia
blood
-extasis
expansion, dilatation
-itis
inflammation
-malacia
softening
-megaly
enlargement
-oma
tumor
-osis
condition, disease, increase
-pathy
disease

B. Operative Suffixes
-centesis
puncture
-ectomy
excision
-lithotomy
incision for, removal of stones
-plasty
surgical correction, plastic repair of
-rhaphy
suture
-scopy
inspection, examination
-stomy
creation of a more or less permanent opening

C. Symptomatic Suffixes
-algia
pain
-lysis
dissolution, breaking down
-oid
like
-osis
increase, condition
-penia
deficiency, decrease

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